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Biological & Medical Serials

THE

# Maritime Medical News

A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

Vol. XVI. HALIFAX, NOVA SCOTIA, AUGUST, 1904. No. 8

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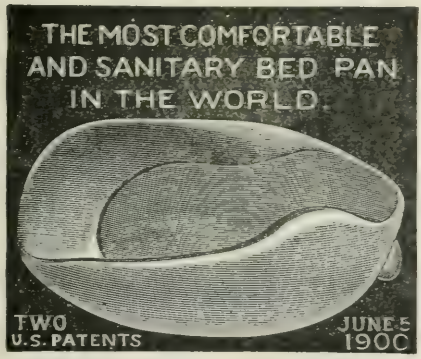


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A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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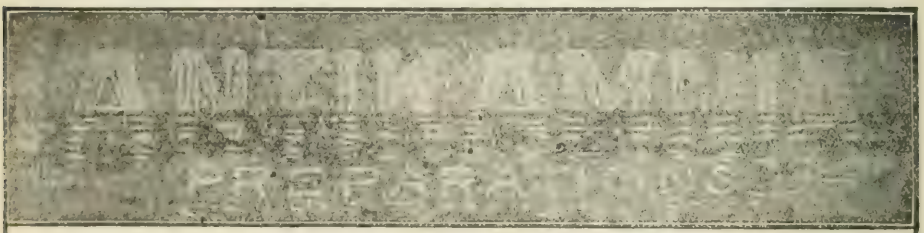


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# MARITIME MEDICAL NEWS.

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## Original Communications.

### CLINICAL FEATURES AND ANATOMICAL FINDINGS.*

By W. F. HAMILTON M. D., Lecturer in Clinical Medicine, McGill University, Montreal.

Mr. President, Ladies and Gentlemen,—The honour that I have in addressing you to-day is much greater than I deserve. Five years ago it was my pleasure and privilege, in response to an invitation from the executive of that year, 1899, to read a paper before your Association, in session at Charlottetown. The kindly treatment received at that meeting, and the pleasant recollections of the fellowship with the members of our profession down by the sea, which I have since cherished, played no small part in deciding me in accepting the second invitation, received but a few weeks since. To have been asked the first time was indeed a great honour, but to have been asked a second time is, to me, a much greater one.

I have realised for the first time in my life the difficulty,—and I had almost said, the distraction,—that one may experience in deciding upon a subject suitable for such a meeting as this. To give you a resume of the advance in medicine made within the past few years would take you over matter at least as familiar to most of you as to myself. It therefore occurred to me that it might be of interest to many of the members to present, in groups, several cases in which diagnostic difficulties had arisen, and to compare the clinical with the anatomical features as revealed by the post mortem examination. I decided therefore to speak to you upon some *clinical features and anatomical findings*. Doubtless it has come within the experience of all here to find at an autopsy several anatomical features

*Address in Medicine read at meeting of Maritime Medical Association, Halifax, July 7th, 1904.

not anticipated in making the diagnosis during life. It is mainly to such cases that I wish to direct your attention for a brief time this morning.

The matter upon which my remarks are based is gathered from my clinical experience during the past ten years in the wards of the hospital with which it is my high privilege to be connected. In a few instances I am indebted to Dr. James Stewart and Dr. C. F. Martin for permission to use their cases. I need scarcely remark that with all our improved means, accurate diagnosis of internal conditions is often most difficult.

We are justly proud of the advances in our methods of diagnosis—the sera-reactions, bacteriological tests, cyto-diagnosis, the skiagraph and fluoroscope, and, I may add, the exploratory incision,—are all of recent acquisition in clinical work. They all have their limitations, and those who use them most frequently and most faithfully will not fail to apply the *ordinary* methods as well. Sydenham's "Natural History Method" of study, without explanations of diseased conditions, was doubtless better than all preceding methods, but it would not have achieved much without Harvey's "Circulation of the Blood", Malpighi's histological work on glands and lungs, or Morgagni's infective spirit of advance along pathological lines. Heirs as we are in these latter days of the records of these and other discoverers, and of as much as it is possible to inherit of the experience of the Fathers in Medicine, we fall far short in so many matters of diagnosis, prognosis and treatment that were we but a little less optimistic we might abandon the field to quacks, mountebanks, "skilly" women, and *prescribing apothecaries*, who in earlier times, as now, swelled the "motley rout of competitors with whom the honest physician had to contend." But, Mr. President and Gentlemen, lest I should wander too far and be chargeable with an aimless digression, let me address myself to my subject.

From among many interesting and instructive cases with lesions of the nervous system, which have recently been observed, three have been chosen as illustrating rather rare anatomical findings,—at least when taken with the clinical features.

N. N., a well developed French Canadian shoemaker, aged 50, came into the ward complaining of pain in the upper part of the abdomen, sharp lancinating pain over the region of the heart, attacks of shortness of breath, and sleeplessness due to palpitation.

In early life he had done very heavy work upon the farm. He was the father of 15 children, and was married a second time, two years before coming under observation. He used tobacco in excess and alcohol in very small quantities. He had never suffered from rheumatism, chorea, or any venereal disease.

As we have stated his chief complaints were of præcordial pain, palpitation and dyspnœa. After a few days of observing the patient

a diagnosis of cardiac dilatation, myocarditis, adherent pericardium, and possibly endocarditis, was made.

The heart was enlarged upward to the second space on the left and right, laterally, on the right almost to the nipple line. Peripherally, there was no evidence of arterio-sclerosis. The urine showed a trace of albumin and was diminished in quantity; otherwise it was normal.

He did not react to treatment with rest, purgation, digitalis and morphia. One afternoon at 2 o'clock the patient complained of a sensation of numbness, extending over the left arm and left foot, becoming general over the left side of the body. A little later the same peculiar sensation was felt on the left side of the face and head. Cheyne-Stokes respiration set in. He sat up in bed, swayed from side to side, turned very pale, and rubbed his left arm and leg complaining that they were cold. His left arm moved about as if paretic. Within a few hours paresis passed into paralysis. The tongue was protruded to the right side. At 11 p. m. there was paresis of the right levator palpebræ, and the lines of the right side of the face seemed less marked than normal. Weakness was the patient's chief complaint; there was no headache nor convulsion. He died 18 hours after complaining of the first sensory disturbance. The terminal features of the case seemed to favor cerebral hæmorrhage or thrombosis.

The autopsy served to confirm the view of dilatation and hypertrophy of the heart; there was no endocarditis. A careful examination of the brain revealed no abnormal features, either in the vessels or brain substance proper, neither hæmorrhage or thrombosis.

One naturally asks the cause for such a widespread paralysis A search through many books of reference throws but little light upon such a condition. So far, I have found but a brief line or two in Osler's Textbook which appears to bear upon the subject, "According to Kolisko, softening of limited areas, sufficient to induce hemiplegia, may be caused by sudden collapse of certain cerebral arteries *from cardiac weakness.*"

From the standpoint of exact diagnosis, the advantage of a careful bacteriological examination of cerebro-spinal fluid, is illustrated by our second case. It is one in which a secondary infection masked the primary condition, and threatened at one time, in the course of the post mortem examination, to set aside the original clinical diagnosis. Stripped of details the story is as follows:—

W. M, aged 6 years, was admitted with signs of cerebro-spinal meningitis. The history was in accordance with the clinical features of the case. He was deaf even when first seen in the ward. His ears showed nothing abnormal on examination by inspection. A lumbar puncture was done and the fluid thus obtained contained the meningococcus intra-cellularis.

The little patient lingered long after the diagnosis was thus confirmed by bacteriological examination of the fluid, dying 67 days from the beginning of the illness.

When the brain was removed at autopsy, the pathologist remarked that it did not present the appearance usually found in epidemic cerebro-spinal meningitis. Extensive suppuration was discovered in both middle ears and mastoid antra. The drum membrane and external canals were normal. A streptococcus infection was present, particularly in the middle ear, while the meningitis was due primarily to the meningococcus intracellularis.

It would appear that in this case, so low did the process of life become after the onset of the disease, that ample opportunity was afforded for other infections to develop.

Not the least interesting of those taken from among the nervous cases, is that of a quarryman, aged 54, who came into the hospital with pain, tenderness and swelling of the right ankle, headache and general weakness. For four weeks, following a chill, he had suffered with his ankle, and for a shorter time with his right shoulder. The headache had been a common complaint of his extending intermittently over many years. The patient's family and personal history were good. He had never had syphilis or rheumatism, and he indulged but lightly in alcohol.

He was a poor, wretched-looking man, older than his years. The mucous membranes were pale. He had emphysema, with marked arteric-sclerosis of palpable vessels, enlarged heart, and an accentuated aortic second sound. There was no albumin in the urine, but on careful sedimentation a few casts were discovered. The right ankle was swollen, tender on pressure, and painful on movement. The nervous system was negative with but two exceptions: an increase of reflexes and an inequality of the pupils, the right being larger than the left (contraction of the left). His temperature was normal or subnormal.

The patient was admitted on the 1st of September, and up to the 4th of that month he had slept well at nights, and at intervals had been troubled somewhat with headache. On the 4th, at 2 o'clock in the afternoon, the temperature rose to 101°, and at 5 o'clock it was 103.3°. He became restless, irrational, and passed his urine involuntarily. Beginning as a tonic spasm and ending in clonic spasms, a sharp general convulsive seizure of three or four minutes duration supervened, in which the head was rotated strongly to the left. After the seizure the patient was restless for a time and then he gradually became himself again in the course of an hour, when the temperature dropped to 101°. There was no paralysis. Five days passed over and but little change was noticed. On three of those days the record is of "no headache"; on the fourth, of "slight headache in the morning."

On the evening of the 10th of September, five days after his first seizure, he had a few twitchings about the face, lost consciousness, his muscles became rigid, and there was involuntary micturition. When he regained consciousness the left leg and arm were almost completely paralysed. The right pupil was much larger than the left. On the following day there was some rigidity of the paralytic limbs. The head was retracted, rotated to the right, and the eyes turned to the right. The face was not affected. The patient's mental state was not clear. The reflexes were increased on the paralysed side; Babinski's sign was present. The patient became completely unconscious, and died on the morning of the 12th day of his stay in the hospital.

The diagnosis was not clear. The complaints led us to regard the patient as the subject of an arthritis of a mild type. The marked rigidity and irregularity of his palpable arteries made positive a diagnosis of arterio-sclerosis and with this a kidney more or less damaged. The patient, however, did not give any symptoms of renal changes, and but little weight was attached to this. The headache was carefully enquired into and, as we have stated, it was a common complaint from time to time over many years, and even when his condition was at its worst, during his final illness, headache when not absent altogether was constantly less marked. Hence as a diagnostic point it was not regarded as of much value. There was no optic neuritis. He had not been subject to convulsive seizures. The febrile temperature with which the convulsion was associated was certainly exceptional, particularly as it preceded the spasm. Viewed, however, in the light of a persistent, though mild arthritis, the fever was not unusual.

Realizing the difficulty of distinguishing between hæmorrhage, thrombosis, and embolism in certain cases of apoplexy, it was felt that such a case was before us. We had a sudden onset, with but brief premonitory symptons, referable to the nervous system, a general convulsion and no paralytic signs remained. A few days intervened between this and the final convulsive seizure which left the patient paralysed on the left side, and then coma rapidly supervened. The diagnosis made was general arterio-sclerosis, arterio-sclerotic kidney, myocarditis, left hemiplegia of hæmorrhagic or thrombotic origin.

Need I tell you of our surprise when we found a suppurative meningitis, secondary to a very small abscess of the scalp, posteriorly in the right parietal region, which was covered by a thin, scale-like scab, and underneath which a localised necrosis of the outer table of the bone had taken place. On examination a portion of the outer table, of irregular shape, and measuring 2 x 1.5 cm., lay loosely in its place and beneath it the inner table seemed intact. Two relatively

large veins connected it with the dura mater, which was rather thick and opaque. Immediately beneath this the most intense purulent meningitis was observed. The inflammatory process was wide-spread bilaterally, and a large collection of pus was found in the median fissure, between the inner aspect of the right hemisphere and extending down to the base of the occipital lobe. There was no basal meningitis.

In reviewing this case we may remark that the main points were in favor of hæmorrhage, general convulsion, loss of consciousness, deep prolonged coma, and marked arterial sclerosis. In the second place a quotation from Gowers, on purulent meningitis, may be recalled, and with this case in view I am sure its truth will be impressed upon our minds. "No form of inflammation, not even the tubercular, presents greater variations in symptoms and course, in proportion to the intensity of the process. I have known slight occasional strabismus, slight retraction of the head, moderate headache, irregular fever and optic neuritis, to be the only symptoms, although after death both cerebral and spinal membranes were bathed in pus and the meningitis certainly commenced a fortnight before death."

In the case just related we had not even one of these diagnostic features, save the headache and irregular fever, which might be found in many conditions.

Another lesson, taught in this decade of hospital experience, is that one should be slow to consider obscure cases referable to the nervous system as *functional*. One may briefly recall a good example.

Miss K. T., aged 35, milliner, came under my care Oct. 30th, 1900, complaining of pain in the back, the left hip, knee and leg. She was of light frame and fairly well nourished. Her history showed that for five years she had complained of pain in the small of her back, which set in gradually, increased in severity and often radiated around to the front of her abdomen. Tight clothing and stooping aggravated the pain. Four months before she came under my notice she felt pain in her left hip and thigh, so severe as to need morphia for its relief. Then after freedom for some time, another attack came on, not so localized as before, all over the left hip, thigh, side of neck and ovarian region; the back was comparatively free. There was a sense of weight and pressure in the top of the head, and she felt as if she were longer than the bed on which she lay. Morphia, bromides, sulphonal and codein had been freely indulged in before coming under my care.

On examination, she was found to be very emotional. There was neither deformity, area of tenderness, limitation of movement, alteration of reflexes, loss of power, wasting of muscles, nor rigidity of lumbar muscles that could be detected. At times she would not undertake voluntary movement of left leg, but it could be moved by

another without pain. Her complaints were so bitter, her requests so importunate, that despite the view of a functional condition at first held, we gave her occasional doses of opium. Hot air and counter-irritation were tried to no good purpose. She was much improved under the judicious care of a special night nurse; she slept better and without drugs. This period lasted for about four weeks when the right hip became painful. By this time our view of a functional condition was becoming doubtful, and again and again we sought an explanation in signs of spinal or other organic disease. Towards the end of January, after three months of worry and dissatisfaction, signs of spinal disease developed. Now the right hip was painful, the left less so. There was a deviation of the upper lumbar spines to the right and a rounded tender mass upon the left.

The course of the case was rapidly downward and death ensued as the result of an attack of broncho-pneumonia. The spinal deformity was due to an angio-sarcoma beginning in the body of the third lumbar vertebra, secondary in adjacent bones and in the sternum.

The protracted history of pain,—its variability, both as to position and intensity; the disproportion between the complaints and the function of the parts apparently most involved, and the improvement following upon special nursing, when considered in relation to the absence of all objective evidence, afforded good reason for the view of functional disturbance. It must be remembered, however, as we review the case, that there were no certain stigmata of hysteria, and that the pain was complained of chiefly and most constantly in the left hip. Pain when constantly referred to one place should be considered as far more likely due to some organic cause than to a functional condition.

Two cases may serve to illustrate the difficulty of diagnosis between pericarditis with effusion and dilatation of the heart. In several textbooks these two conditions, it would appear, need scarcely ever be confounded, and in several journal articles the differential diagnostic features are set forth. The experience of not a few trustworthy clinicians, however, serves to show that errors of diagnosis are quite within the range of possibility.

The first case was that of a boy, aged 12, who had frequently complained of a sore throat. In the early part of his brief and fatal illness he had arthritis in the ankles and right knee, and shortly after became dyspnœic and complained of great præcordial distress. The pulse was rapid, very irregular, both in rhythm and in volume. There were signs of fluid in the right pleura; the præcordia bulged and showed pulsation, wide-spread on both sides of the sternum. There was dulness across the chest at the 5th rib, measuring 16 cm., 7 cm. to the right and 9 cm. to the left of the middle line. Traube's space was obliterated. The heart sounds became weaker; the extent

of dulness increased upward towards the neck into the second interspace. The friction rub persisted and death supervened. A diagnosis was made of sero-fibrinous pericarditis with right pleural effusion, and possibly of endocarditis.

The autopsy confirmed the diagnosis of mitral endocarditis, and of pleurisy with effusion. There was an acute plastic pericarditis, but no pericardial effusion. The heart filled the greater part of the chest, which measured 18.5 cm. over all,—the heart itself occupying 14.5 cm.

The case had several points supporting the view of pericarditis with effusion, e. g., the pain and the friction sound; the increase of præcordial dulness, both laterally and upwards, the cardiac impulse within the area of cardiac dulness on the left and the change of percussion note in Traube's space.

The test of the right line of dulness, upon which several writers lay considerable stress as a help in the diagnosis between dilatation and pericarditis with effusion, fails for obvious reasons in this case, for at the autopsy the heart filled the whole of the lower portion of the exposed thoracic cavity, and was enlarged especially to the right (8 cm. right, 4th rib; 6.5 cm. left, 6th rib).

By this case and that which immediately follows, Rotch's angle sign is shown not to be infallible. Dr. Middleton, writing in the Glasgow Medical Journal, '99, describes the same condition,—dulness in Rotch's angle,—in a case of tricuspid stenosis. Upward extension of the dulness fails also, as shown by this case and the one following.

The second case was that of a boy, P. T., 11 years of age, who was the subject of a rheumatic endocarditis, and had been under observation from time to time for upwards of four years. When last admitted to the hospital he complained of severe pain in the chest. His pulse was 140 and there was marked increase of præcordial dulness, both to the right and left, measuring transversely four inches, while the note in the second left interspace was impaired. The angle of dulness between the liver and heart was obtuse. The condition grew rapidly worse, the cardiac dulness increasing from four inches to six, and in a few days to seven and a half inches. There was a to-and-fro friction murmur heard over the centre of the sternum, the heart sounds were weak, and the general condition was extremely bad. Believing that the patient was the subject of pericarditis with effusion threatening his life it was decided to puncture the pericardium. This was accordingly done. The fourth right interspace, close to the sternum, was chosen and three ounces of bloody fluid were withdrawn. The patient died 22 hours after. The clinical diagnosis was pericarditis with effusion, mitral regurgitation and cardiac hypertrophy.

The autopsy showed acute fibrinous pericarditis with adhesions and marked dilatation of the heart with hypertrophy and chronic mitral endocarditis.*

Before the patient died it was thought in all probability the heart had been punctured in attempting to withdraw fluid from the pericardium, and at autopsy it was shown that such was the case—the right auricle had been tapped.

According to Gibson and others, the danger of puncturing the heart in tapping the pericardium has been greatly exaggerated. Fearing, however, that such an accident might occur in this case, special attention was given to the pulse during this operation, and no change could be observed. According to Sloan (Edin. Med. Journ., '95) and Evans (Trans. Clin. Soc. Lon. '75) and Broadbent (third edition), puncture of the heart is not uncommon, and has been followed by few serious results. Indeed, there is evidence supporting the view that it may do much good, and some have even advocated the operation for the relief of greatly dilated hearts.

A small group of pulmonary cases reminds us of a few misleading features that may arise in some of our most common diseases:—

No. 1. (3512), a male, aged 60 years, complained of shortness of breath, cough and expectoration. He had been sick for several years, and cyanosis, anæmia and emaciation were marked. His fingers were decidedly clubbed. His chest was emphysematous, with no dulness at any part; both moist and dry rales were widespread. He was slightly febrile and very weak. The sputum examination was negative to tests for tubercle bacilli. The course of his case was that of gradual failure, and he died with a diagnosis of chronic bronchitis, emphysema and general arterio-sclerosis.

The autopsy revealed chronic ulcerative tuberculosis of the lungs, fibrosis, chronic pleurisy, emphysema, etc

No. 2. (7540), female, aged 55 years, complained of pain in the stomach, gas on the stomach and colic. She had been ill for about nine months with weakness and emaciation. There was an irregular temperature, sometimes febrile and sometimes normal. The chest was long with considerable retraction in the supra and infra-clavicular regions. There was dulness over both apices, but more marked on the right, with moist rales. The yellowish sputum was very scanty, and no tubercle bacilli were found in it. A diagnosis of chronic fibroid phthisis was made, with marasmus, due possibly to latent malignant disease.

The anatomical findings were, endothelioma of the right lung; secondary carcinoma of the stomach, etc.

No. 3, (3326), that of a man aged 27 years, whose illness began rather indefinitely some weeks before coming to the hospital. He

*B. M. J., 1896, Vol. 1, pp. 817. Edin. Med. Journ., 1895, Vol. 40, pp. 673. Trans. Clin. Soc., London, 1875, Vol. 8, pp. 169.

complained of cough, blood in sputa and difficulty in swallowing solids. He was irregularly febrile, weak, emaciated and dyspnœic. There was dulness in the right base posteriorly; the breath sounds were blowing and moist rales were heard over the right lung. A very few tubercle bacilli were reported as found in the sputum. The diagnosis was pulmonary tuberculosis.

The anatomical findings were those of carcinoma of the œsophagus, bilateral gangrene of the lung, right empyema, etc.

This group of cases serves to emphasize the following well known clinical facts:—

1. That tuberculosis may be completely masked by the co-existence of emphysema, and in such cases the diagnosis is all the more difficult because of the rarity, and indeed at times the total absence of the destructive bacillus.

2. Case 2 illustrates the difficulty of diagnosis of malignant disease of the lung, as well as the fact that it may often be confounded with chronic fibroid phthisis.

3. There may be in the sputa other acid-fast bacilli than the tubercle bacillus, a fact that is well known. In Case 3, hæmoptysis and the finding of such a bacillus doubtless led to the mistake in diagnosis.

In a group of two cases we have the common complaint—shortness of breath. The dyspnœa was urgent when the patients were admitted, and as they illustrate rather rare and obscure conditions their histories may be briefly sketched:—

Case 1.—A female, aged 65 years, had suffered intermittently with shortness of breath for eight years and was regarded as an asthmatic. She was in the ward but a few hours before death, and the clinical diagnosis was Broncho-pneumonia with nephritis.

The autopsy served to sustain the diagnosis, but it was found that the middle lobe of the thyroid gland was greatly enlarged and formed a mass which pressed upon the trachea, so that from the middle third downward the lumen of the trachea was but a mere slit from side to side. There was intense tracheitis, pulmonary congestion and an early diplococcus infection. The lateral lobes of the thyroid were not enlarged and in life the physician's attention had not been called to this region.

(Dr. Adami has reported this case more fully in the *Lancet* of February, 1904.)

Case 2 was that of a man, aged 61 years, who, in addition to dyspnœa, had loss of voice For two months before coming under observation he had been troubled with cough and shortness of breath, and, for four weeks before, his voice had been reduced to a whisper. There was a syphilitic infection of several years standing. He had lost weight. The dyspnœa was extreme, with both inspiratory and expiratory stridor; the chest was emphysematous; there was no

visible or palpable pulsation, and tracheal tugging was not present. The vocal cords were in extreme abduction and on phonation the arytenoideus muscle was the only one brought into play, making the rima glottis a very large ellipse. The fluoroscope showed nothing more than an abnormally broad shadow at the upper part of the mediastinum. There was no pulsation discovered on the broadened shadow. The diagnosis lay between an aneurysm of the aorta and malignant disease involving the mediastinum. The absence of tracheal tugging and of pulsation on fluoroscopic examination added to the obscurity of the diagnosis.

At the autopsy the trachea was found definitely narrowed just above its bifurcation, the wall being pushed in and eroded. The left bronchus was also involved. A purulent lobular pneumonia hastened the end. Almost immediately above the valves, the aorta underwent rapid distension. On the posterior wall at the juncture of the ascending portion with the arch, and extending behind the orifices of the cervical branches, was a left saccular aneurysmal pouch. This pouch, filled with firm, whitish clots, projected back and compressed the lower part of the trachea and left bronchus. But because of its position and of its being filled with clot the characteristic sign of pulsation was not forthcoming.

We may next consider a most interesting case of staphylococcus infection.

W. N., (7762), aged 39 years, fell ill six weeks before he came under our notice with an attack of abdominal pain accompanied by fever. He was told he had appendicitis. When admitted he complained of severe pain in the stomach, loss of weight, weakness and occasional nausea. There was a history of indigestion, without vomiting, for several years. During the past two years he had taken freely of alcohol in various forms. He was very anæmic, his skin being of a subicteroid cast. The blood count showed 3,000,000 red cells, 4,600 white cells, with 55% of hæmoglobin. The various systems carefully examined, gave but little direct evidence leading to a satisfactory diagnosis. A few moist rales were heard at both bases, and the epigastrium was slightly tender on palpation. The liver could be felt. The urine held a trace of albumin. The possible conditions uppermost in my mind were: tuberculosis and early cirrhosis of the liver.

There developed gradually during the next four weeks right pleural effusion, ascites and left pleural effusion, arthritis of the left ankle, and an increasing amount of albumin in the urine with casts. The ascitic fluid and pleural effusion were withdrawn in part and carefully examined, both as to cells and bacteria present. Endothelial cells, polymorpho-nuclear leucocytes and a few lymphocytes were present in the fluid from the chest. Numerous cocci were also found. The same forms were found in the peritoneal fluid. A cul-

ture taken from the blood revealed the same organism, which Dr. Bruere, who kindly did the examination for me, pronounced as the staphylococcus pyogenes albus. From this it was clear that we had to deal with a case of staphylococcus infection. Some ninety ounces of fluid were taken from the abdomen, and about twenty-seven from the right pleura.

At the height of the patient's illness the urine contained casts cylindroids, and an increased amount of albumin. There was a marked improvement in all the symptoms when the fluid from the chest and abdomen was withdrawn. The temperature after a few days became normal, the urine normal, and one month after the first blood culture a second culture was taken in the same way as before and was free from microbes. He made a good recovery.

The source of infection, or rather the site, could not be defined. But it is not infrequent to find this form of infection with cholecystitis and cholelithiasis. In our patient's history, however, no support for this view could be found.

I wish further to remark upon the great advantage and high degree of satisfaction the clinician enjoys when thus associated with the skilled laboratory worker. It is felt that many cases, not widely different to this, pass under the diagnosis of healed tuberculosis or cirrhosis of the liver, or in the event of death when no autopsy is made, die of one or both of these diseases.

The diagnosis of abdominal cases is usually very difficult. With the assurance born of asepsis, exploratory incision is recommended and submitted to with increasing frequency, and in not a few instances it is a short cut to diagnosis. It is to be hoped, however, that the day will never come when confronted by a grave abdominal case, the physician, without the greatest care, passes his patient over to the surgeon for exploratory laparotomy.

When one reflects that the diagnosis of appendicitis, now thought to be so easy, has been developed within the last 25 years, one need not wonder that other conditions, which by their very nature are obscure, yet remain with but few, if indeed any, *characteristic* features. In reviewing the abdominal cases which come before one in an hospital practice, it is clear that in many of these a diagnosis is impossible without a laparotomy or a post mortem examination. These we must pass over. There is a group of cases, however, in which we think a diagnosis should be made, and yet an experience with such cases teaches the lesson that our clinical observations and conclusions are often wrong.

Cirrhosis of the liver, tuberculous peritonitis and abdominal cancer, are among the more common conditions met with in clinical medicine in the diagnosis of which many an error has been made not infrequently.

1. The man in middle life, after several years of alcoholic excesses,—after a diagnosis of cirrhosis of the liver,—dies of cancer of the stomach and tuberculous peritonitis—his liver being found free

2. A patient of more than 60 years of age, with a history of alcoholism, dies of syphilitic cirrhosis.

3. Another patient with jaundice, a rough, palpable tender liver, and severe abdominal pain, becomes greatly emaciated, and after losing 60 pints of fluid from the peritoneum by tapping, dies with a diagnosis of cancer of the liver. The autopsy reveals a small cirrhotic liver.

4. Another patient with no alcoholic habits, but with a history of recent malignant disease in the left breast, and with signs of recurrence in the axillary glands, dies with a diagnosis of recurrent carcinoma of the liver, while the autopsy reveals an atrophic cirrhosis.

5. A man past middle life with a clear alcoholic history in early life, from 18 to 42 years of age, had fever, jaundice and an enlarged liver and spleen. A diagnosis of hypertrophic cirrhosis was made. The anatomical diagnosis was cancer of the common bile duct, secondary in the pancreas, obstruction in the bile ducts and throughout the liver, with necrosis of the liver.

6. Our sixth case of this group is that of a female aged 70. She was febrile, her liver and spleen were enlarged. She had jaundice and hæmorrhoids. A diagnosis of mixed cirrhosis was made, which in the light of pathological anatomy had to be revised to read: carcinoma of the pancreas, secondary in liver and elsewhere.

7. And finally, while considering our abdominal cases we find a young man, aged 27, dying of carcinoma of the stomach, secondary in the peritoneum. The clinical features had been interpreted as those due to tuberculous peritonitis, for he had spat up some clear blood and was febrile. There was fluid in the peritoneum and he had passed some blood by the bowel.

Remarks: I. In considering these and similar cases clinically, we have taken into account the etiology, particularly where cirrhotic changes were suspected. In that case, where "5 to 50 glasses of liquor of all kinds" had been indulged in for years, the liver was free. The recent work of Boix upon the etiology of cirrhosis of the liver, in which he shows that butyric acid, valerianic acid, and particularly acetic acid, are active in inducing the changes of cirrhosis, gives a new view-point for this subject, lessening in some degree at least the etiological value of alcohol.

II. The specific gravity of the fluid withdrawn from the peritoneum is not conclusive.

III. The amount withdrawn, and frequency of tappings, has not been found to agree with Dr. Hale-White's opinion that in cirrhosis the patient rarely survives more than one tapping.

IV. The findings in the liver clinically may be very misleading. In one of our cases enlargement was made apparent by fluid above it pressing it down; while the organ itself was shrunken and small.

V. Cyto-diagnosis promises but little of diagnostic value.

It may be said that a differential diagnosis between cirrhosis of the liver and cancer of the pancreas, secondary in the liver, can have no practical results in the direction of the treatment of those aged patients whose cases we have here recorded. There are few who, on this account, will lose interest in the clinical manifestations of disease. Our system of medical education, provided as it is with ample means for pathological anatomy, teaches the physician to think anatomically, as Charcot remarked years ago when describing the services rendered by pathology and autopsy work. In this connection he says that the question whether "do you cure more patients than they cured of old," is a very indiscreet one, and to it he replies in the words of Behier,— "Be sure that practice, without incessant scientific renewal, will very soon become a belated and stereotyped routine."

It has been felt, Mr. President, that some hardihood was required for one to address one's fellow-practitioners, as I have done, on what might be styled diagnostic errors, yet I have regarded these as among the most valuable of my clinical experiences, teaching me more, perhaps, than many successful diagnoses, and it is to be hoped that this sketch of some of my observations is not wholly devoid of interest.

Gentlemen, I thank you.

# THE USE OF THE X-RAY IN THE DIAGNOSIS OF DISEASES OF THE BONES.*

By E. A. Codman, M. D., Boston, Mass.

It would be extremely uninteresting to you to listen to a description of each form of bone disease in which I have found the X-ray useful, or to listen to a rehersal of a series of cases, but I trust that my method of using the X-ray in diagnosis may be worth your attention. In what I have to say to-night I shall limit myself to diseases of the bones, although the same method of interpretation is valuable in the explanation of any X-ray plate.

My particular hobby in X-ray work has been "interpretation." By the interpretation of a plate I mean the drawing of conclusions from it as to the actual anatomical or pathological condition of the part which has been taken. I fear that I have neglected electrical and photographic technique shamefully, for I have felt that the thing which is worth a physician's time in X-ray work is his ability to draw conclusions from his plates after they are taken. Any man without a medical education may soon learn to take a technically good X-ray picture, but it requires an accurate anatomical and pathological knowledge to interpret one correctly after it is taken.

The structure of machines, coils, tubes, anodes and cathodes may be changed indefinitely in the next 20 years, but the anatomy of the bones, and the manner in which they are affected with disease, will be the same, and it is with these same diseases that experience in interpretation will prove valuable. The ultimate object is to obtain knowledge which will assist in curing the disease.

To this end there are four steps.

First. The knowledge of the essential characteristics of an X-ray picture, i.e., that it is a projection or chart of the densities of the different parts of an object.

Second The knowledge of normal X-ray anatomy—*i. e.*, the appearances made by the normal bones in an X-ray picture.

Third. The knowledge of the pathology of different forms of bone disease, *i. e.*, the exact manner in which each invades the bone.

Fourth. The ability to reconstruct a picture of the pathological conditions in the individual case from the inferences deduced from X-ray pictures of it.

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*Read at meeting of Maritime Medical Association, Halifax, July 6th, 1904.

When we have a competent knowledge of these four essentials we may reason as follows:

(Blackboard.) This X-ray plate differs from the normal appearance of the tibia in that it shows a thickening of the cortical bone of the shaft. Since the shaft is affected, it is more likely to be syphilis than tuberculosis which almost invariably affects the epiphysis. Since there is no loss of bone substance or formation of a sequestrum it is not osteomyelitis. The patient is young, therefore it is not Paget's disease. There is no chronic lung disease, therefore, it is not osteo-arthropathy pneumonique, etc., etc.

(Sherlock Holmes would have been a great interpreter of X-ray pictures.)

Let me speak a little more fully of each of my four divisions.

### First. The knowledge of the essential characteristic of an X-ray picture.

The X-ray picture or skiagraph is not like any other kind of a picture we are familiar with. I have racked my brains to try to find something to compare it with. My best definition is a chart of the densities of the different portions of an object Stop to think a minute! It is not a shadow, for a shadow is merely an outline bounding a homogeneous interior. It is not a photograph because a photograph shows merely outline and the surface. It is not a median section for a median section gives no idea of what lies on either side. It is not a picture of an interior for you may see in it portions of the object which are on both sides.

It really shows much more than any other kind of a picture with which we are familiar, for like the shadow and the photograph, it gives the outline, and like the median section and interior-view, it gives some knowledge of what lies inside the bone. To this Maritime Medical Association I may compare it to a graphic representation of a chart of soundings where, instead of the number of fathoms, is registered in black and white, the number of atoms which each ray meets in traversing the bone. The less the number of atoms met in each portion of the bone, the deeper and darker will be the imprint left by the ray on the plate.

One must remember that the greater the atomic weight of an object or substance the more obstruction will it offer in the path of the ray. This is equally true of each little part of that object or substance.

I need not remind you, too, that the portions of an object which are not in contact with the plate are enlarged, because the light radiates from a single point. In this, skiagraphs resemble shadow pictures.

SECOND.—THE KNOWLEDGE OF NORMAL X-RAY ANATOMY.

X-ray anatomy differs greatly from the osteology which we learnt at the medical school. We then learnt to describe the surface of bones and paid little attention to the density of their various parts. In the X-ray picture, we recognize the bones entirely from their outline unless we happen to remember the look of their sections, but in the X-ray the outline surrounds a chart of densities instead of surface markings. In the skiagraph the sustentaculum tali and the unciform process appear as dense rings in the middle of the os calcis and unciform bone, instead of protuberances on their surfaces. The epiphyseal junctions in children appear as irregular over-lapping ellipses. The olecranon fossa seems like a hole in the lower end of the humerus.

I can illustrate these points better when we come to the lantern slides.

THIRD. THE KNOWLEDGE OF THE PATHOLOGY OF DIFFERENT FORMS OF BONE DISEASE.

I mean by this, especially, the particular mode in which each disease invades the bone. How have our predecessors in medicine learned to classify the different forms of bone disease? By the study at operations or autopsy of the different characteristics of each disease, confirmed by the clinical history and the microscope. For instance, in syphilis of the bone they have given us the following facts:—

A syphilitic bone has no odor—the X-ray cannot tell us this.

Gummatous infiltration of a bone is not purulent, but a grayish or yellowish granulation-like tissue—the X-ray cannot tell us this.

The surface of syphilitic bones is rough to the touch and the periosteum adheres with more than ordinary tenacity to it—but the X-ray cannot tell us this.

So we might go on with other diseases, mentioning many things which the X-ray will not tell us.

Those of us who have had experience do not expect it to tell how a bone smells or how it looks in cross section or how it feels on the surface. We may, however, infer how it smells or how it looks and how it feels after we have found out some of the other things, for fortunately our predecessors have told us other things about syphilis of the bones.

For instance, syphilis almost always affects the shaft instead of the epiphysis. This we can find out from the X-ray.

Syphilis seldom forms sequestra. This we can find out from the X-ray.

When one bone in the body is affected by syphilis, other bones are

apt to be also, even if giving no symptons. This we can find out by the X-ray.

Take another disease, *e g.*, Rickets. The X-ray tells us that the zone of ossification is broadened, that the adjacent surfaces of diaphysis and epiphysis are irregular, that there are areas of little density in the broadened ends of the diaphysis, that there is increased cortical bone on the concave side of the distorted long bones, etc., etc. It does not tell us whether the epiphyseal line is red or yellow or how the concave side smells, but it does tell us enough so that we should not make one mistake in a hundred in making a diagnosis of rickets. We might then infer that the epiphyseal line is purple because we know that the section of a rachitic bone shows a purple epiphyseal line.

Let us suppose an instance and draw our deductions.

(Blackboard.) Here we have a skiagraph of a tibia showing a loss of substance in its lower end. This much we can be sure the X-ray says truly, but when we begin to infer what tissue of little density lies in that cavity where the loss of substance has occurred, we begin to tread on dangerous ground. Now we know from pathology that such a loss of substance may be caused by an abscess in the bone, or a medullary sarcoma, or a chondroma, or a gumma. We examine the X-ray more closely. If it is an abscess it is likely to have a certain amount of new bone formation in its wall. This will make the abscess cavity appear to be surrounded by a dark wall. If the light area is due to a medullary sarcoma, we may see trabeculæ passing across it here and there, giving it a mottled appearance. If a chondroma, it has probably an erosion or a protuberance when seen in the lateral view. If a gumma, probably there are other lesions in other bones.

Perhaps, we shall have recourse to the clinical history for the most important evidence. I would no more make a diagnosis on the X-ray alone than I would say pneumonia on the strength of the stethoscopic examination alone. Sometimes I should feel pretty sure in either case, but I should like to hear a cough, or to see the temperature chart and a little rusty sputum, before speaking positively.

I have no intention of claiming to make all diagnosis from the X-ray, but it is of great assistance. What it does tell us is how the inorganic portion of the bone is affected, and this is a great assistance if our knowledge of pathology can tell us the way each disease affects the inorganic portion.

FOURTH.—THE ABILITY TO RECONSTRUCT A PICTURE OF THE PATHOLOGICAL CONDITIONS IN THE INDIVIDUAL CASE FROM THE INFERENCES DEDUCTED FROM X-RAY PICTURES.

This fourth requisition means a thorough knowledge of all the

other three steps. One must understand the distortions which are characteristic of every X-ray picture. For instance, that the X-ray picture of a cube may appear like two squares, a larger and a smaller, or like two superimposed trapezoids varying in shape according to the angle from which the rays come. One must know how these distortions affect the normal X-ray anatomy of the various bones. One must know the pathology of each disease thoroughly. Finally, one must reconstruct the cube from the larger and smaller square, the actual bone from the X-ray chart, the kind of disease from the particular way in which the bone is invaded, and the odor, the appearance and the feeling from knowledge of pathology of the disease itself.

Is this way more difficult than deducing the appearance of the heart from what you hear of its murmurs? Can you not form a mental picture of the appearance of the kidney from your examination of the urine?

Expressed simply, my statement is this: If you know how to interpret it, a good X-ray will tell you much of the condition of the inorganic portion of the bone. Different diseases affect the inorganic portions of the bone in different ways. If you know what these different ways are, you may get great help in your diagnosis from the X-ray.

To illustrate what I have been saying, I will show some lantern slides, and go over some of the characteristics of each disease in detail

# ALBUMEN AND CASTS—THEIR RELATION TO LESIONS OF THE KIDNEY.*

By L. M. Murray, M. D., Halifax.

All the men who practice medicine know the difficulty in affections of the kidney, of connecting the clinical evidence available with any certain pathological entity. And although albumen in the urine has long been considered fairly good and sufficient evidence of some pathological change in the kidney—Bright having published his monogram in 1827,—as early as 1832, Spittal, in his inaugural thesis at Edinburgh, while granting the views of Bright, stated that he was a trifle too absolute, and that the presence of albumen in the urine was not always a certain sign of renal change. Following this, albuminuria became known, and has ever since been regarded, as a symptom only, and of late years the number of conditions, other than renal conditions, in which albumen has been found in the urine have been greatly increased.

Casts, first discovered in 1842, were not known to be of importance in the diagnosis of kidney lesions for some years, and even now many of the men who write books seem to be very indefinite in their opinion, and some of them positively inconsistent in their non-application of casts to disease of the kidney. So that I shall refer to some of the conditions in which albumen is found in the urine without the presence of a kidney lesion, but much more than this, I would give to the urinary tube cast a much greater value than it has at present in the diagnosis of lesions of the kidney.

Albumen, as found in the urine, must necessarily come from the blood, as it is the only tissue in connection with the urinary tract which could give us a sufficient quantity to detect by our methods. The simplest way for it to find its way into the urine would be to have bleeding from the kidney, bladder, or from some portion of the urinary tract. The ordinary way is for the blood serum to transude from the kidney capillaries just as it does from the capillaries in other portions of the body under similar conditions.

The circumstances which give rise to this transudation of serum into the urine would be one of four causes :—

1st.—Inflammatory changes in the walls of the blood vessels by which they become more permeable.

2nd.—Changes in the blood itself by which it transudes more readily through the capillaries.

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*Read before Maritime Medical Association, Halifax, July 6th, 1904.

3rd.—Changes in the blood pressure.

4th.—Changes in the walls of the capillaries other than inflammatory by which they are rendered more permeable.

The significance of albumen in the urine depends therefore upon its causation, which for instance when the blood itself is at fault may be dependent upon an anæmia, or, when the blood pressure is at fault, may be due to some disturbance of the nervous system, and so its presence does not tell us of the presence of a lesion of the kidney any more than another symptom like "cough" would necessarily mean that we had a lesion of the lung.

But passing on to the very important subject of tube casts in the urine, it will answer my purpose to consider the whole group, hyaline, granular, epithelial and others, under the general head of casts. But with one exception, viz. the long more or less fibrillar structure which may be seen in almost any urine, and which is classed by some authors as a mucous cast, and by others is known as a cylindroid, it very infrequently if ever has its origin in the kidney and cannot be included under the general term of tube cast.

The cast then, having its origin in the kidney tubule, is supposed to arise by some change in the secreting cells lining these tubules. It is possible that albuminous substances derived from the blood may take some part in their formation. But as casts do not appear in the urine in the so called functional albuminurias, such as cyclic albuminuria, dietetic albuminuria or the postural albuminuria of Sir W. Broadbent, in which conditions we do not have any change in the kidney substance, it would appear that the important factor in the formation of casts is that we have some change in the secreting cells lining the kidney tubules. As the normal functions of these cells is not the formation of casts, this change must be a pathological one.

In the examination of urine for casts and having for its object the detection of a kidney lesion, we may have any one of a number of possibilities.

1st.—Albumen and casts may be present together.

2nd.—Albumen and casts may be present at one examination, and at the next examination only casts may be found. This apparent difference in the result may extend over a long period.

3rd.—There may be albumen and no casts.

4th.—There may be casts and no albumen, but at each later examination casts and albumen be found together.

5th.—Casts may be present without albumen.

The first class of cases, viz. those having albumen and casts present together in the urine, cover the greater number of the cases in which we may expect a kidney lesion. They are the common cases and do not call for any special remarks. But I would remind you that it is not so much the finding of the albumen which draws your attention

to the kidney, but more the presence of casts along with the albumen which makes you reasonably sure of some kidney lesion.

In the second group of cases where the result is variable and we may have casts and albumen one day and another day casts alone—the urine is of a low sp. gr., usually 1008-1012, and of a low urea index. This urinary picture usually occurs along with an anæmia of from 65-75% hæmoglobin, and with more or less well marked cardio-vascular change, giving a fairly clear clinical picture of a chronic interstitial nephritis. I would have you bear in mind that the finding of casts in these cases is constant, even when albumen may be absent for weeks at a time.

The third group of cases, where we have albumen and no casts, is of importance only in that it will be found that the urine has an alkaline reaction. This alkalinity is in many cases due to a fermentation of the urine, possibly while it is still in the bladder, and during this process, casts, being of a very delicate texture and not at all stable, always become broken up so that they cannot be seen. I do not believe that casts ever exist in a urine with a decided alkaline reaction, even when the alkalinity is not due to fermentation.

In this class of cases then, even when a well marked kidney lesion is present, we are unable to find casts, not because a lesion of the kidney is not present, but because they have become dissolved or broken up as soon as formed.

Members of the fourth group, where we at first find casts alone and later albumen and casts persist together, are not often seen by the practitioner, because as a rule we do not see our cases early enough. I have, however, seen one such case occurring in the service of Dr. Lafleur of the Montreal General Hospital. The patient was a man 58 years old who complained of headache, nausea, and vomiting. He had well marked arterio-sclerosis and enlargement of the heart to the left. His urine, which was of a low sp. gr., in many examinations extending over two or three weeks, revealed only casts. Later, however, albumen appeared, at first as a trace only, but rapidly increasing in amount. He then began to have distinct uræmic symptoms and died about four months after his first admission. Post mortem (and I give this case from memory only) his kidneys showed a marked interstital change following the type seen in arterio-sclerotic kidney, but with very extensive degeneration of the secreting cells. This case has given to me a lasting impression on the importance of casts in the early diagnosis of kidney lesions.

The fifth division where casts are found without albumen being present is a very large one and includes every degree of a chronic kidney lesion from a simple congestion to an interstitial nephritis. This renal picture is probably most frequently seen in conditions of passive congestion from cardiac or other causes, and keeping in mind the fact that passive congestion is a pathological condition in which

we have at least a diminished nutrition, but later fibrosis, I admit that I cannot understand the reasoning of authors who inform you that because casts are sometimes found in cases of chronic congestion that they are of no clinical significance in certain cases, for in my mind it is the first clinical evidence that a degenerative process has begun.

Other examples of this class are seen in irritation of the kidney, the simplest example of which is in the administration of an irritant like salicylic acid, when we frequently find casts in the urine. In jaundice, from different causes, casts are often found, and if the urine were examined in all cases of acute gastro-intestinal indigestion, it would be found that in most, if not in all, of these cases casts are present in the urine, and unless the bowels be cleaned out and rendered more aseptic, this kidney irritation may go on to an actual acute nephritis.

In grouping the above three examples, I would not attempt to define where a kidney irritation ends and a kidney inflammation begins. But I think it reasonable that if the irritation be sufficient to cause an abnormal function in the kidney epithelium as shown by the presence of casts, even when the irritant be mild but continued, it would lead to a definite kidney change.

Further examples of this important fifth class are seen in cases of cirrhosis of the liver; here the presence of casts may be referable either to an irritant of liver origin or to a definite interstitial kidney change.

In the acute fevers and in gout, casts are frequently found alone in the urine. In this connection I would remind you of the frequency of nephritis, either acute or chronic, in these diseases and infer the possibility that cases shown by casts only and cases of well marked inflammation may be but different degrees of the same process.

In the case of a much enlarged liver, reported by Dr. Arthur Birt, of Berwick, before the N. S. Branch of the British Medical Association, which was looked upon by him as one of a diffuse syphilitic liver, and in which the enormous syphilitic infiltration in the liver substance rapidly subsided under the influence of potass. iodid, it is interesting to note, considering the possibility of the kidney having been subject to the same infiltration, that at the time the liver was enlarged, casts were plentiful in the urine, and that during the reduction in the size of the liver under the treatment, the casts disappeared entirely from the urine.

Finally we have the cases of undoubted chronic interstitial nephritis in which the kidney lesion is known clinically and in which we may have casts in the urine alone.

You will see that in all these cases, first those of undoubted kidney lesion, and second in the cases where we might well suspect a kidney

lesion, casts are to be found. I do not know how it is possible that in one case the casts are of importance, and that in another case, with the same kind of casts, to say that they have no clinical significance.

Therefore with a consideration of all the above I would suggest:

1st.—That albumen in the urine may depend on a cause far removed from the kidney.

2nd.—That tube casts in the urine are the resultant of some change in the parenchymatous cells of the kidney, and are therefore symptomatic of a definite kidney lesion which may be slight but often leading to very distinct and permanent change in the kidney substance.

## HOSPITAL NOTES.—1904.

By Murray MacLaren, M. D., M. R. C. S., St. John, N. B.

Padua. At the General Hospital, Professor Bassini has his clinic of thirty beds. There was no opportunity, unfortunately, of seeing this surgeon perform the operation which he introduced for the radical cure of hernia. It may be said, however, that Prof. Bassini still adheres to the procedure as laid down in his early description of the operation.

He showed seven cases which had been operated upon for hernia during the previous eleven days. All of these showed a subnormal temperature continuously from time of operation. Two of the patients were out of bed and standing.

Prof. Bassini follows this practice of getting patients out of bed ten days after operation for hernia. A very short period of rest in bed it would appear to most surgeons.

He was seen to remove a sarcoma of the thigh which was attached to the linea aspera, just above the knee-joint. The tumor was enucleated, and the case was, of course, to be kept under observation in case of possible recurrence.

Prof. Bassini's technique is very simple, but careful, and he makes very little use of assistants, threading his own needles, handling the instruments, etc., himself.

Operating gloves were not worn, and chloroform was given as the anæsthetic. Starch bandages were used in place of the ordinary gauze bandages, and these were noticed to be in general use in Vienna and Breslau. They make a firm, comfortable application over the soft dressings, and very thin wood splints can readily be incorporated.

The hospital at Padua, wards and operating room included, however, are not modern and do not show the advances now made in hospital architecture.

Vienna. The Allgemeines Krankenhaus has not changed materially in appearance in recent years, and still possesses the great attraction of showing an enormous amount of work of all varieties in medicine and surgery, within a compact area. The surgical and gynæcological clinics are improved, and a new surgical department is in course of construction.

Prof. Eiselsberg while operating uses cotton gloves and a mask, as

do his numerous assistants. This was also noticed in other clinics in Vienna, and in Mikulicz's clinic in Breslau.

The anæsthetic used in Eiselsberg's clinic is Schleich's anæsthetic mixture. This consists of two parts of ether, one of chloroform and one of ether petroleum (benzine), and is given on an inhaler somewhat similar to the ordinary chloroform inhaler. It had been given in 6,000 cases without a death, but in several instances observed, the anæsthesia was not at all smooth, and in one case the condition was somewhat alarming.

Eiselsberg, like other German surgeons, makes a large abdominal incision and gives the fullest view of the deeper structures.

Prof. Von Mosetig Moorhof has a method of dealing with tubercular disease of joints and bones and with the cavities, resulting from osteomyelitis, which seems very effective. The cases which had undergone treatment showed surprisingly good results, while advanced cases ordinarily requiring amputation were considered well worthy of trial and apparently with very good reason. Mosetig secures perfect access by laying open cavities thoroughly, removes diseased structures freely, and is very radical in his conservatism in order to save the part. His technique and operative skill are all that can be desired. No doubt all these factors enter into the attainment of results which are simply splendid.

Briefly, Mosetig's method consists in completely clearing out the disease, whether from joints or bones, with curettes, burrs, etc., rendering the cavity dry and aseptic as possible, then pouring into and filling this cavity with a specially prepared mixture of iodoform, oil of sesame and spermaceti, at the temperature of 80° C., which soon sets and is called "plumbing," and the soft tissues closed over. He claims that this mass is gradually absorbed, giving place to fibrous tissue and then bone, and shows X-ray photographs taken at various times to prove this. Spaces whether bony or soft are filled with the mixture. In the case of knee-joint, the cartilage only is removed and the tubercular foci then scraped out and "plumbed." Bony cavities after cleansing are dried out with hot air before "plumbing."

As an illustration, he showed a case in good condition in which the astragalus, cuboid, scaphoid, cuneiforms and heads of metatarsal bones had been removed and the os calcis curetted.

He has treated successfully in this way several cases of old standing empyema of antrum of Highmore.

In Prof. Lorenz' clinic, the plaster of Paris work must be seen to be appreciated. For talipes, the bandages are applied to be worn six months, boots being made to wear over and the skin is cleansed by a slip of cotton under the bandage.

In cases of knock-knee under seventeen years of age, the femur is fractured at the epiphyseal cartilage, by placing the limb in an iron frame. In cases over seventeen years of age, when this cartilage is ossified, McEwan's operation is done. For application to hands before using plaster, the following ointment is used:—lanolin; vaselini, aa 150; ol. vaselini, 90; ol. bergamot gtt. ix.

At Prof. Lang's clinic much interesting plastic work may be seen. Lupus is freely excised and skin flaps brought over, the skin is anæsthetized by injection of cocaine one quarter of one per cent with a small quantity of tonagan or sometimes adrenalin added.

To first mark out the lines of incision fuchsin is used and over it nitrate of silver, either in stick or 50 per cent. solution, is applied and in this way the line is made lasting.

Breslau. One would naturally expect to find at Prof. Mikulicz's clinic a thorough and complete aseptic technique, and one is not disappointed for here it has reached a high mark. The spectator, as in other places, must wear a linen coat and rubbers and keep behind the railing; he must not walk over the operating room floor. The operator and assistants wear, in addition to operating suits and rubbers, masks and cotton gloves.

To prepare the hands, they are first washed in soap and water, using woodwool instead of a brush, then for five minutes the hands are scrubbed in an alcoholic solution of soap. This solution is subsequently distilled to prevent waste of spirit. At present, there is on trial, the injection of nucleic acid previous to or at the time of operation. Leucocytosis is thus produced and may combat possible infection.

Mikulicz's assistant, Dr. Sanberbruch, has recently experimented with dogs and found that he could open the chest wall without the lung collapsing, provided the atmospheric pressure on the outer side of the chest wall was somewhat reduced.

An air-tight cabinet has therefore been constructed in which Mikulicz operates on œsophageal and pulmonary cases. The cabinet is about nine feet square, of iron frame with glass slides. The second and third operations, and the first two pulmonary cases to be dealt with in the cabinet, were witnessed. Mikulicz and four assistants were in the cabinet for forty minutes without discomfort, the patient's head is outside in order to breathe normal air, the neck surrounded with a rubber collar. The air within is reduced by pumps in pressure of about 8 m. m., while it is constantly being renewed. By another contrivance, the lower portion of the patient's body is also not subjected to the diminished pressure.

In one case a bronchial fistula was closed and in another a sarcoma of a rib was excised, the lung in both cases bobbing up in the wound, in contrast to the collapse which would otherwise have occurred.

The anæsthetic was taken quietly and well.

Prof. Neisser, the discoverer of the gonococcus, has the clinic for skin and venereal diseases. The skin diseases consist largely of tubercular lesions. Tuberculin is freely used as a diagnostic aid in all suspected tubercular cases. All possible cases of lupus receive this test. This clinic is famous for its preparation of beautiful wax models of skin lesions, and many examples from the collection are to be seen this year at the St. Louis Exposition.

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## CASE OF GALL STONE IN COMMON DUCT, WITHOUT PAIN—OPERATION—RECOVERY.*

By A. B. Atherton, M. D., Fredericton, N. B.

March 20, 1902.—I was asked by Dr. E. B. Fisher, of Marysville, to see Mrs. J. C., aged 45, mother of twelve children, the youngest born two years ago. She suckled this child twenty-one months. The menses have been rather scanty of late, and have not appeared as frequently as usual. Has lost forty lbs. in the last eighteen months, her present weight being one hundred and thirty-five pounds. Has never in her life had any unusual abdominal pain. About ten months ago began to have attacks of vomiting at irregular intervals, but they were unaccompanied by pain. Sometimes she would vomit several times in twenty-four hours, and at others vomiting would not trouble her for a week. During the last three months these attacks have become more and more severe, and jaundice has appeared and has gradually deepened until now the skin is very dark and covered with papules and pustules, due no doubt to her continual scratching to relieve the intolerable itching. During the last few weeks, on several occasions, the attacks of vomiting have been ushered in by a rigor. No pain is however felt, though there is some soreness in the epigastric region afterwards. Dr. Fisher says the jaundice is deepened for a time after each attack. The stools have been clay-colored.

On examination, the belly is flat, no swelling or tumor being felt anywhere; neither is there any tenderness at present, as some days have lapsed since one of her attacks of vomiting. Liver dulness rather less than normal.

As the cause of the biliary obstruction was uncertain, and various medicinal remedies had been tried without avail, exploratory incision was advised. This was refused by patient and relatives.

*Read before Meeting of Maritime Medical Association, Halifax, July 6th, 1904.

After three weeks, however, the patient in the meantime having grown weaker and not improving otherwise, she consented to an operation.

April 5.—Operation. Chloroform, followed by ether, given by Dr. Mullin; assistance rendered by Dr. Fisher. An incision, five or six inches long, made through outer border of right rectus. There was considerable bleeding; controlled by ligatures. The gall-bladder found much contracted, being about size of a large hickory nut. Opened, but no stone found in it. On examining the gall-ducts, a single, round, hard stone of size of a small marble found impacted in the common duct. The latter incised and the stone removed. A little bile escaped, which was caught on gauze sponges. No other stone found. One or two sutures put in duct wound, but as it was difficult to introduce them and patient was not in a good condition to stand a prolonged operation, I left most of incision in duct open; a rubber drainage-tube with a strip of iodoform gauze by its side was then introduced down to the duct, and as these were conducted to the abdominal wound close alongside of the opened gall-bladder, I used no other drain for the latter.

The peritoneal wound was now closed by a continous suture of cat-gut; also the muscle and fascia by the same. Finally interrupted silk-worm gut sutures to skin, space of course left for exit of drains. The abdominal rubber-tube was then connected with a smaller long rubber-tube leading into a bottle by bedside. Iodoform gauze, etc., as dressing.

In evening of day of operation the pulse was 100 and temp. 99°. She had received $\frac{1}{10}$ gr. of strychnine hypodermically, and pint of saline with half an ounce of spts vin. rect. as an enema.

Dressings had to be changed eight hours after operation, because they were well saturated with bloody serum and a little bile.

April 5, 9 a. m.—Had $\frac{1}{8}$ gr. morphine hypodermically and slept $4\frac{1}{2}$ hours. No vomiting. Pulse 96, temp. 99°. Five ounces of bile in bottle.

April 6.—Slept $3\frac{1}{2}$ hours. Iodoform gauze removed from abdominal cavity. Rubber tube left. About nine ozs. of bile have been discharged through tube in twenty-four hours. A little also on dressings. Pulse 110 temp. 99.4°.

April 11.—Doing well. Bowels were well moved on the 8th. Bile runs freely yet from wound. Dressings changed two to three times a day. Pulse 84, temp. nearly normal. Jaundice is gradually disappearing.

April 17.—Some bleeding for last day or two from the raw surfaces. Bile flows out pretty freely yet. Jaundice all gone.

April 21.—Tube inclined to come out. Removed.

April 29th.—Doing fairly well; pulse 80, temperature runs from normal to 99.2°. Considerable bile discharged still. Appetite good. Gaining in flesh.

May 8.—Doing well. Very little bile seen now.

June 2.—Left hospital for her home in the country. Feels and looks well. Bile has ceased to be discharged. Stools normal in color. Wound about healed.

Remarks.—As far as I can learn from the literature of the subject at my command, it must be very seldom that a gall-stone is found impacted in the common duct, where no history of gall-stone colic can be obtained and no pain worth mentioning accompanies the dyspeptic symptoms present in such cases. This patient would only admit that she felt some *soreness* in the upper abdomen after her attacks of vomiting.

With steadily increasing jaundice and loss of flesh, one would naturally strongly suspect the presence of a malignant or other growth obstructing the common duct. I have myself seen a very small tumor producing such symptoms and finally causing the death of the patient.

The deepening of the jaundice, together with the rigors, would perhaps favour to some extent the diagnosis of gall-stones, but these being largely due to cholangitis with infection might also be met with in the case of a growth obstructing the lumen of the duct, and setting up an inflammation there.

Finally, this case serves to show how important it is to make an exploratory opening, in order to clear up any doubt as to diagnosis in a serious abdominal condition. When such a course can be pursued with so little risk, as at present, we believe that the patient should more frequently get the benefit of this procedure, and that before he or she becomes so reduced as to render one unfit to stand any further operative measures which may be required to effect a cure.

# THE PUBLIC HEALTH ACT IN NOVA SCOTIA.*

By A. P. Reid, M. D., Middleton, N. S.

Our health laws are of comparatively recent and slow growth, and not until Dr. Wm. McKay of Cape Breton gave attention to it in his place in the House did it assume its present form. The next advance was at the instance of the Hon. W. S. Fielding, Provincial Secretary, who instituted the *Provincial Board of Health*, which body inaugurated the Provincial Bacteriological Laboratory, the value of which to the province and profession it would be needless for me to dwell on as you are individually intimate with its work. At its inception it was under the charge of Dr. W. H. Hattie, now superintendent of the Nova Scotia hospital. On his resignation the work was continued by the late much lamented Dr. Halliday, and is now most successfully carried on by our confrere, Dr. L. M. Murray.

The third step in progress was the requirement that every municipality and town should appoint a health officer.

At the instance of the Nova Scotia Medical Society last year the Provincial Board of Health was abolished, and in its place the administration of the health laws is made a Department under the Provincial Secretary with an executive officer styled *Provincial Health Officer.*

Our health laws, if carried out in spirit or even in letter, would be fairly satisfactory, but it takes time to educate the public up to its requirements. The ordinary response to new regulations is "we have got along very well hitherto, why change;" and again the question of expense causes a great desire to hang back in the enacting and carrying out of the law. For every amendment leading to increased efficiency means an increased expense, and hence abnegation of demands for hygienic improvement. Nor do I think we will have our statutes complied with until the public are so educated that they will feelingly appreciate the facts in pathology that have been so definitely established during the past few years.

So long have people suffered from tubercle, diphtheria, pneumonia, typhoid and eruptive fevers, infantile diarrhœa, cholera nostras, etc., that they look at them as they do at the weather as a dispensation beyond their control and put up with it.

All public health acts are based on the assumption that these contagious diseases, which chiefly swell our mortality lists, and as well grievously increase our financial losses, are avoidable, and that compliance in letter and spirit with the act would place them not only

*Read before Meeting of Maritime Medical Association, Halifax, July 7th 1904.

under control but in the end exterminate them. Until the public thoroughly appreciate the facts, the carrying out of the health acts will be beset with difficulties.

I have so far not mentioned smallpox as I look on it as the most easily controlled of all infectious diseases and at the present time adds but few cases to the mortality lists. To some extent it is a blessing in disguise, because its onset is so insidious and its outbreak so pronounced that it startles the community and causes an effort (too often spasmodic) to carry out hygienic laws. I fear however that many thousands of our people have yet to die from preventable disease before the proper means are adopted for the preservation of human life, which so far as the community is concerned seems to place a much higher estimate of that of the beasts of the field. Until it is generally recognized that a death from tuberculosis means ignorance or carelessness, on the part of the deceased or his advisers-or both-and the same may be said of other infectious diseases.

The question which really presents itself is—How may we educate the people? No doubt much can be done by visits, lectures and demonstrations, but I have little hope that much headway will be made with our present adult population; hence we must look to the instruction of the coming generation and to do so. the public school must be our main resource. This; if judiciously managed, should ultimate in success and here it may be in order to give a quotation from my last report to the government.

"The above considerations in the most marked manner emphasize this fact, that the government, the school authorities, and the people should insist that an adequate system be adopted to the end that the coming generation may be so educated that they may avoid the many pitfalls that the present one is foundering through.

The public school is the only means available that presents itself to me, and regular and definite sanitary instruction should not only be given to every pupil but so instilled into his mind that he will not forget it, but also that he will feel an individual interest in it; that it is for his own private use, neglect of which brings condign punishment.

We now have health readers, all very good in their way, but they do not reach down to this practical point.

### HOW TO AVOID DISEASE.

It is of a certain value to know something about the heart, muscles, bones, nerves, brain, etc., that in life enables us to perform our varied duties, but of much more value.

To know what causes tuberculosis (the great white plague, socalled,) and what we know of the tubercle bacillus, its mode of propagation and tenacity of life.

To know how vaccination protects from smallpox. The press of the

future may thus be spared many inanities that now appear from time to time.

To know that the pneumococcus pneumoniæ is always with us, and in us, and is harmless until some imprudence enables it to get in its lethal work.

To know that a common fly can carry the poisons of typhoid, cholera, erysipelas, and different kinds of sepsis on its hairy padded foot, and implant on our food active germs of disease.

To know that certain families of mosquitoes can not only rob us of our blood, and give most pointed annoyance, but as well inject into our tissues the germs which produce malaria, or the more lethal yellow fever.

To know that a rag of clothing lying in a garret for years may be able to convey most virulent types of smallpox, scarlet fever, etc.

To know that simple cleanliness is the most valuable element in the surgeon's armamentarium, and surgical cleanliness is the synonym for the nearest attainable perfection, and as well an essential part in the wonderful success of the surgical science of to-day.

To know that there can not be too much care used in disinfection in the presence of infectious disease—that by so doing a sanitary officer is not airing a hobby—but strictly attending to business.

And so I might go on, I think enough reasons are given to substantiate the claim made for special sanitary instruction in schools. This would not be a novelty, as it is being carried out at present in several States of the U. S., as in Michigan and Indiana. Germane to this, and a practical means of carrying it out, is the idea which is elaborated in the following quotation of a resolution of the Canadian Medical Association, and correspondence connected therewith.

### DEPARTMENT OF HEALTH.

The following important resolution, moved by Dr. E. P. Lachapelle, and seconded by Dr. J. K. Jones, met with hearty approval:

"Whereas, public health, with all that is comprised in the term sanitary science, has acquired great prominence in all civilized countries; and whereas, enormously practical results have been secured to the community at large by the creation of health departments under governmental supervison and control; and whereas, greater authority and usefulness are given to health regulations and suggestions when they emanate from an acknowledged government department;

"Therefore, be it resolved, that in the opinion of the Canadian Medical Association now in session, the time is opportune for the Dominion Government to earnestly consider the expediency of creating a separate department of Public Health, under one of the existing Ministers, so that regulations, suggestions and correspondence, in such health matters as fall within the jurisdiction of the Federal Government,

may be issued with the authority of a department of Public Health ; and that copies of this resolution be sent by the general secretary to the Governor-General-in-Council and to the Hon. Minister of Agriculture."

Dr. Roddick and Senator Sullivan both spoke strongly in favor of the resolution, which was carried unanimously.

OFFICE OF THE DIRECTOR-GENERAL OF PUBLIC HEALTH,

OTTAWA, September 23rd 1902.

DEAR DOCTOR,—At the meeting of the Canadian Medical Association in Montreal last week, the enclosed copy of a resolution was passed there in favor of the recognition of the importance of public health and sanitary science, by the creation of a sub-department of Public Health, to deal with such matters relating thereto as come within the jurisdiction of the Dominion Government.

If this idea commends itself to you, as I believe it does, I would suggest that a resolution on similar lines, passed by your Provincial Board, would strengthen the movement in this direction.

The extract is taken from the Montreal Daily Herald of the 18th insant.

Yours very truly,

F. MONTIZAMBERT, M. D.,

*Director-General of Public Health*

DR, A. P. REID, ESQ., M. D.,
*Secretary Prov. Board of Health,*
Middleton, N. S.

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80 UNION AVENUE,

MONTREAL, April 4, 1903.

MY DEAR DOCTOR,—It is my intention at an early date to introduce in the House of Commons the following resolution :

"Resolved, that it is expedient in the public interest to constitute a department of public health for the Dominion, charged with the execution of the various duties which are or may be imposed upon or assumed by the government for the protection of the public health and the prevention and mitigation of disease ; and that such department of public health be administered under the direction of a minister of the crown, in conjunction with one of the existing departments of the government."

It has occurred to me that if your Provincial Board of Health favored the idea they might be willing to pass a resolution strengthening my hands.

I should consider it a personal favor if you would kindly place the matter before your Board.

Yours faithfully,

T. G. RODDICK.

DR. REID,

*Secretary Provincial Board of Health,*

Middleton, N. S.

PROVINCIAL SECRETARY'S OFFICE,

HALIFAX, Sept. 30th, 1902.

MY DEAR SIR,—I am in receipt of your letter of the 27th inst., with inclosures from Dr. Montizambert.

The idea suggested by him for the creation of a sub-department of public health commends itself to me, and I have no objections to the Provincial Board of Health, through you, endorsing the idea as strongly as possible. I return enclosures.

G. H. MURRAY,

*Provincial Secretary*

DR. A. P. REID,

*Secretary Provincial Board of Health,*

Middleton, N. S.

There is another subject that calls for attention were there time, I refer to the work being done in England in reference to working up the subject of cancer and malignant disease, but at present I'll defer.

# UTERINE HÆMORRHAGES AND THEIR CAUSE.*

By Thomas S. Cullen, M. B., Associate Professor of Gynæcology, the Johns Hopkins University, Baltimore.

General practitioners are continually meeting with cases of uterine hæmorrhage, and are often at a loss to determine the exact cause of the flow. In recent years we have gained a much clearer insight into the various pathological conditions that may cause uterine bleeding. Out knowledge has been due chiefly to two factors, early operation where pelvic lesions are present, and a careful microscopical examination of all tissues removed at operation.

I shall, in the brief period at my disposal, look upon the subject from the standpoint of the general practitioner and see just what clues have been furnished by the pathologist and surgeon.

On making a list of the chief sources of uterine hæmorrhage, I have found that they fall into five main groups :—

(1.) Hæmorrhages dependent upon constitutional tendency to bleed.
(2.) Hæmorrhages due to inflammatory conditions of the uterus or appendages.
(3.) Hæmorrhages incident to pregnancy, extra or intra-uterine.
(4.) Hæmorrhages due to the presence of tumors.
(5.) Hæmorrhages due to carcinoma or sarcoma of the uterus.

Hæmorrhages may be present shortly after birth. Here within twenty-four hours after the child is born, small balls of mucus mixed with blood may escape from the vagina. These usually disappear after the fifth or sixth day and do not return. We do not know their cause. Again, in young girls the menstrual period is often very irregular, sometimes not coming on for months at a time and then amounting almost to flooding. In such cases it is often difficult to determine whether we are dealing with a period or with an intra-menstrual hæmorrhage.

Hæmorrhages dependent upon a constitutional tendency.—Nearly all of you are familiar with a few cases of this kind. We have to deal with a young woman, dark in complexion and complaining of flooding at the menstrual periods. On questioning her closely, it is frequently found that her parents or other members of the immediate family show a marked tendency to bleed after slight injuries, or if the patient is of middle age she has had an alarming post-partum hæmorrhage with each child. On examining such an individual nothing abnormal will usually be detected in pelvic organs, and the microscopical examin-

*Address delivered before the Maritime Medical Association at Halifax, N. S., July 6. 1904.

ation of the uterine mucosa will show that it is apparently normal. In such cases we are dealing with a peculiar tendency towards bleeding, and as there is a normal escape of blood from the uterus at each menstrual period the hæmorrhage naturally takes place from the endometrium, instead of from another part of the body.

Several years ago my attention was called to another group of cases unassociated with the general tendency toward hæmorrhage. These patients commenced to have very profuse menstrual hæmorrhages when about twenty years of age, and the hæmorrhage was so alarming that it was necessary to curette every three or four months. On microscopical examination I found hypertrophy of the tissue between the uterine glands. Otherwise the mucosa was normal. This hæmorrhagic tendency disappeared about the thirtieth year in the cases with which I am familiar. Dr. H. Meek, of London, had two patients (sisters) giving similar symptoms, and in each, after systematic curettage every four months for a number of years, the cure was permanent. Under this group we may possibly include hæmorrhage due to dilated veins in the endometrium. Here, however, the general tendency towards hæmorrhage is wanting. I have in mind a patient suffering from severe hæmorrhage and a diagnosis of cancer of the body of the uterus was made and hysterectomy contemplated. As a matter of precaution however, curettings were examined and markedly dilated veins were found in the mucosa. The glands were perfectly normal. After several curettings the patient had no further trouble. Why the veins become so distended it is difficult to surmise, but such conditions are occasionally present.

The tendency towards uterine hæmorrhage is often in evidence where the uterine mucosa is moderately thickened and the glands enlarged and dilated. Given a scraping from such a case one can say with almost absolute certainty that the patient is suffering from uterine hæmorrhage.

Hæmorrhages due to inflammatory conditions of the uterus or appendages.—The physician not infrequently sees a patient who gives a history of an old miscarriage followed by some elevation of temperature or giving a fairly distinct history of gonorrhœa. On making a pelvic examination the uterus is found to be normal in size. Its mobility is slightly restricted and there is a faint suspicion that the tubes and ovaries are bound down. The patient complains of a leucorrhœal discharge and of frequent and slight uterine hæmorrhages. In such cases the physician is at a loss to know the exact cause of the bleeding and cancer may be suspected If the diagnosis cannot be made then the safest plan will be to curette and examine the scrapings. Much care should, however, be exercised as manipulation of the uterus may rekindle an old inflammation and pelvic peritonitis result. Examination of the scrapings in such a case will show a varying degree of endometritis, but absolutely no

evidence of cancer. If the pelvic adhesions be severed and the uterus freed these hæmorrhages usually disappear. The hæmorrhages may of course be much aggravated if a polypoid endometritis exist or if there be double pus tubes. It must be remembered that pelvic inflammatory lesions are by no means always accompanied by uterine hæmorrhages.

Hæmorrhages incident to pregnancy.—Under this heading I will refer to four important pathological conditions: (1) miscarriage. (2), hydatidiform mole; (3), chorioepithelioma; (4), tubal pregnancy;

Miscarriage.—It is hardly necessary for me to more than mention this condition. In the first place it is so frequently met with, and then as a rule the history is clear. There are cases, however, where the data are insufficient and where the patient denies pregnancy. Such cases are often confusing. I have had a patient come, saying that three weeks before consulting me she had had a miscarriage, and yet on careful questioning, and after a pelvic examination I felt sure that she was suffering from a tubal pregnancy. In all cases where doubt exists examination of the uterine contents will give a clue. If the pregnancy be intra-uterine then the scrapings will yield placental villi either well preserved or at least retaining their outlines. The presence of the villi is proof positive of the intra-uterine pregnancy. If the fœtus has escaped the placenta usually remains, but if this has been expelled small fragments are then found, and we have the typical decidual formation still clearly visible and showing evidence of inflammation.

Hydatidiform moles.—These are not very common. The patient has given a history of conception and then after a few months when movement is looked for, none is detected, and frequently there is a bloody discharge, often somewhat like brick dust. The uterus is globular and elastic, the cervix hard and the breasts diminished in size. Were one not cognizant of the facts the diagnosis of a globular myomatous uterus might readily be made—in fact, I reported a case two years ago where we were almost sure that the growth was a myoma until after examination under ether. This disease is due to a cystic degeneration of the placental villi. These cystic villi with their secondary branches roughly look like bunches of grapes. On curetting large quantities of small cysts escape. They do not resemble anything else—so the diagnosis is certain. All these cases should be carefully watched, as malignant changes are peculiarly prone to follow and may in fact have commenced and engrafted themselves on to the uterus prior to the expulsion of the mole. If uterine hæmorrhages recur within a few weeks or months after removal of the mole, a careful vaginal examination should be made at once to see if any uterine nodules exist and uterine scrapings should be made to determine definitely if any malignant growth be present.

Chorioepithelioma.—This is a disease until recent years unknown. It never occurs except after pregnancy, and is due to a malignant change in the placenta and possibly in the decidua. It may follow a simple miscarriage or an apparently normal labour, but is very frequent after a hydatidiform mole. It has in a few instances developed subsequent to a tubal pregnancy. Given a recent pregnancy, miscarriage or mole, followed in a few weeks or months by copious uterine hæmorrhages, we must immediately suspect chorioepithelioma, or, as it is frequently termed, deciduoma malignum. On examining the uterus it is usually found enlarged and may be nodular, while in the vagina a bright red nodular growth which readily bleeds is often detected. This is a secondary growth. In a certain number of cases both ovaries are converted into multiple corpus luteum cysts which completely block the pelvis. The uterine growth is peculiarly prone to give rise to lung metastases. These soon lead to pulmonary hæmorrhages. If chorioepithelioma be suspected microscopical examination of the uterine mucosa should usually indicate clearly whether the disease is present or not. If it exists, immediate and complete hysterectomy is the only chance. The delay of a day may prove fatal, as metastases occur so rapidly.

Tubal pregnancy.—To Lawson Tait we owe so much for our knowledge of this subject. A few years ago the history and course of the disease was little known. Now it is upon as firm and scientific a basis as appendicitis—indeed, so proficient have some practitioners become that the diagnosis is frequently made before the tube has ruptured. Although the disease is supposed to be comparatively rare, I have seen and operated upon six cases within one month. Given a patient who has always been regular, with sudden suppression of the period, followed in a few days or weeks by a faint bloody discharge and, possibly, a little pain on one or the other side of the uterus, we must at once suspect a tubal pregnancy and will not often be mistaken. Sometimes the period has come on at the regular time and yet, as it were, drag along for weeks only to be followed by sudden rupture of the tube with the usual signs of collapse due to internal hæmorrhage. Whenever the menstrual period is suggestive of tubal pregnancy and a satisfactory pelvic examination is impossible on account of abdominal rigidity, then an ether examination should be at once made, as little force as possible being used as the tube may rupture. In every case where the diagnosis of tubal pregnancy seems definite the abdomen should be opened at once and the tube removed. Before rupture its removal is easy and fraught with little danger. After rupture the loss of blood may be so alarming that operation is out of the question, or, if the pelvis be filled with the old clots, there is considerable danger of intestinal obstruction or of a fæcal fistula are developing. Uterine hæmorrhages accompanying tubal pregnancy most suggestive and the entire picture is, as a rule, not more difficult.

A certain number of cases of pelvic peritonitis, however, present symptoms that closely mimic tubal pregnancy.

Hæmorrhages due to the presence of uterine tumors.—Myomata. The most common uterine tumors are the myomata. With their various situations and size you are familiar. Doubtless many of you have wondered why in some cases the hæmorrhage was very slight or entirely wanting even although the tumor was very large, while on the other hand, although the nodule was small, alarming bleeding occurred. The amount of hæmorrhage depends almost entirely upon the location of the tumor. If it be subperitoneal or interstitial and does not encroach upon the uterine mucosa, then we will have little bleeding, but if it projects into the uterine cavity then there will almost certainly be severe hæmorrhage—in fact, a submucous myoma not over an inch in diameter is sometimes accompanied by such severe flooding that the patient's life is in jeopardy. While a subperitoneal tumor of sixty pounds weight may not be accompanied by any bleeding whatsoever and only cause discomfort by its size and by pressing upon the pelvic vessels and nerves. In all cases of myoma with hæmorrhage, we must remember the possible co-existence of adeno-carcinoma of the body of the uterus, as I have noted the combination in a goodly number of cases.

Sarcomatous degeneration of myomata.—During the last five years I have paid particular attention to malignant changes in myomata. These are invariably of a sarcomatous nature. Several cases have come under observation The older writers spoke of recurrent fibroids. In these cases, at frequent intervals, submucous myomatous looking tumors were expelled. On histological examination it was found that quite a number of them were sarcomatous in character. The sarcomata develop in the myomata. If a myoma be subperitoneal, then the malignant process soon extends to the intestines and surrounding structures. If interstitial, then secondary nodules are prone to develop in the uterine wall and may project into the cavity of the uterus. If a sarcoma develops in a submucous myoma then portions will from time to time be forced out of the uterus. Given a myoma that has remained dormant for years and that commences to grow rapidly, immediate and total hysterectomy is imperative. In myoma cases with hæmorrhage the diagnosis is comparatively easy, as we have an enlarged and usually nodular uterus to give us the clue. We must, however, always remember the possible co-existence of sarcoma or carcinoma.

Sarcoma of the uterus.—Sarcoma of the uterus is relatively rare and cannot clinically be easily differentiated from cancer. Although occasionally present in the cervix it usually commences in the body of the uterus, and while showing a tendency to bleed, the hæmorrhage is usually not so severe as is noted with cancer. The exact diagnosis is only of interest to the pathologist, as it cannot be clearly established,

except on histological examination, and further, as the treatment of cases of sarcoma and carcinoma is identical—namely, complete abdominal hysterectomy.

Adeno-myoma of the uterus.—This occurs in about 2 per cent. of all myoma cases and is usually accompanied by free uterine hæmorrhages. The inner uterine walls are converted into a coarse-textured diffuse myomatous tissue and the uterine mucosa flows into the chinks between muscle bundles. At each menstrual period this mucosa between muscle bundles naturally swells up, and on account of the increased tension thus produced, gives rise to much uterine pain, and at the same time it pours out its quota of the menstrual blood. This added to the normal amount given off by the uterine mucosa causes profuse hæmorrhage. As the uterine mucosa itself is normal, scrapings will give us no clue. The condition, while very interesting to the clinician, can only be diagnosed after removal of the uterus. I have examined over twenty cases of this character at the Johns Hopkins hospital.

Cancer of the uterus.—We now come to the most frequent and dreaded cause of uterine hæmorrhage—cancer of the uterus. The mucous membrane of the uterus is of three varieties—that of the vaginal portion of the cervix, which closely resembles skin, that lining the cervical canal, consisting of branching glands and secreting mucus, and that lining the uterine cavity, consisting of tubular glands. From each of these three varieties of mucosa different forms of cancer may develop.

Cancer of the outer or vaginal portion of the cervix may roughly resemble a cauliflower growth. It bleeds so easily on account of the great number of blood vessels it contains, and the various blood vessels have so little support that the merest touch is sufficient to rub the tops off the ends of them and free oozing follows.

Adeno-carcinoma of the cervix, or the variety from the cervical canal, consists of glands which penetrate in all directions and may grow entirely through the cervix, but giving rise to much bleeding.

Cancer of the body of the uterus also consists of glands. It forms tree-like growths in the uterine cavity and also penetrates the uterine walls.

While cancer of the uterus may develop in early life, it is most common after the thirty-fifth year. Whenever there is a uterine hæmorrhage that cannot be accounted for the uterus should be carefully examined to see if there be any signs of cancer as it is only in the early stages of the growth that a cure may be hoped for. If the cervix be especially hard at any one point or show little prickle-like points that bleed easily, then a wedge about a quarter of an inch broad and half an inch in depth should be cut out, put in alcohol or formalin and sent at once to the pathologist for examination. If the cervix be normal, then the body and cervical canal should be

thoroughly curretted on all sides, and the scrapings sent to the pathologist. The mucous membrane in health, as seen under the microscope, is just as different from that of cancer as are two totally different patterns of wall paper.

Much has been said about the treatment of cancer of the uterus and great improvements inaugurated in the operative technique. As has been pointed out elsewhere, the only hope lies in the early diagnosis by the family physician. Unfortunately in a good many cases there are few, if any, signs of cancer until the disease is far advanced and operation out of the question. As a typical example I may mention a lady 69 years of age, whom I saw in consultation in St. Louis, less than two weeks ago. Her first hæmorrhage occurred within a month of the time she came for operation, and yet on vaginal examination the entire cervix was involved and the left broad ligament fixed by the growth. I fully believe that in the near future the prediction of Dr. Kelly and others will be verified—namely, that every woman will present herself for examination at least three or four times yearly. In this way if any growth be present it will be gotten at in its incipiency. Our first duty as physicians is to educate women as to the absolute necessity of having any irregularity of menstruation or any uterine hæmorrhage carefully investigated at once. When they learn the seriousness of delay and the satisfactory results that may be obtained by prompt attention, many more will be saved.

In the short time at my disposal no attempt has been made to enter much into detail. I have given you nothing new, but have endeavored to merely group the various cases of uterine hæmorrhage in such manner that they can be easily understood.

# PROTECTION.—NON-POLITICAL.

By Henry P. Clay, M. D., Pugwash, N. S.

A few of my brother practitioners have had the temerity to call me a crank. If, for persistent endeavour to secure a legitimate financial recognition from Incorporations and Governments, for professional services, I am called a crank, I can only say that I glory in shame. Two years ago at New Glasgow, I called the attention of the Nova Scotia Medical Society to certain inconsistencies that obtained with regard to the profession's relation to the public; and I am glad to say that as a result of such calling, we have in Nova Scotia a Health Act, which is a great improvement over the old one, and we have the thin edge of the wedge entered for a betterment of our fees for evidence in courts of law and for making autopsies for the benefit of coroners juries.

At a meeting of the Nova Scotia Medical Society held last evening a resolution was passed endorsing the action of the Lunenburg-Queens Medical Society in refusing to examine for life insurance at a less fee than $5.00. I do not know if the provinces of New Brunswick and Prince Edward Island have been similarly treated by the insurance people with Nova Scotia, but great credit and honor are due to the profession in Lunenburg-Queens for the determined, manly and professional stand taken in the matter of life insurance examinations. To a man they have resisted the tempter, and what is possible in those two heroic counties is possible not only in Nova Scotia, the Maritime Provinces but in the whole Dominion.

At the annual meeting of the Cumberland County Medical Association in January last, resolutions strongly endorsing the action of the Lunenburg-Queens medicals was adopted and a crusade against cheap examinations inaugurated. Owing to some difficulty between the active and indolent members of the County Society it was deemed advisable to let the matter remain in *statu quo* and have it brought before the Maritime and Provincial Associations, so as to ensure concerted action by those who were not only interested in the profession as a means of living but were anxious to maintain the dignity of the greatest philanthrophic combination of the century.

I may be considered pessimistic but I claim that it is useless to contribute to a Dominion Protective Association whereby some one, who, by unfortuitous providence of chance, has become

*Read before Meeting of Maritime Medical Association, Halifax, July 6th 1904.

registered under provincial laws, may make a break through sheer ignorance and claim the protection of such association in courts of law, while the same individual for the sake of the mighty dollar would examine a life insurance applicant for any fee so long as it fell in his mit. We, of Nova Scotia, have decided to wage a fight with the insurance companies and as two out of the many companies now pay the fee of $5.00, which is but an ordinary consultation fee, it is up to you, gentlemen of the Maritime Associotion, to heed the Macedonian cry and come over and help us, help us raise the standard of professional dignity. so that instead of being dictated to we may make our terms and with your encouragement live up to them.

Another grave matter to which I desire briefly to call your attention is the scale of fees for medical and surgical attendance served up by the employees of the Intercolonial and other government railroads. This matter was discussed by our County Society, and a Committee appointed to interview the minister in the premises. As, however, Cumberland County is but a small factor so far as mileage is concerned it was again thought better to bring the subject before this Association with a view to having such steps taken as would ensure a legitimate recognition of the doctor's rights, instead of having him dictated to by a body of men whose sole idea seems to be to see how cheaply they can get medical or surgical services. Seventy cents for a visit and medicine does not seem a fair recognition of the waste of grey matter following a call on a sick railway employee. Shall we stand for this any longer? Again, every medical man who has had anything to do with the Marine and Fisheries Department, which is under the immediately control of the Dominion Government. must recognize the unfair scale of fees, which has been forced upon the profession by those who know nothing of the trials and tribulations of the ordinary practitioners. In this connection as well as in that of the Railway Departments, a competent Medical Officer should be placed in charge of each department; one who would mete out practice to a long suffering portion of the community.

Another class with which we as medical men have largely to do is the noble red man. God's poor we are always ready to aid but why we should treat free of charge the government poor God only knows. In this province at least the poor Indian is very much in evidence and his wants are legion. I have been frequently called upon to minister to Indian necessities and the only satisfaction I can get from the official agent is that there is no fund from which such services can be paid.

Having thus briefly called your attention to three of the most glaring abuses to which we are subjects as ministers to the suffering public, may I suggest that some action be taken by the united provinces in medical wisdom assembled, whereby these ills may be corrected and we can feel at least that we are on a way to the same plan that other professions have attained in Society and Government circles.

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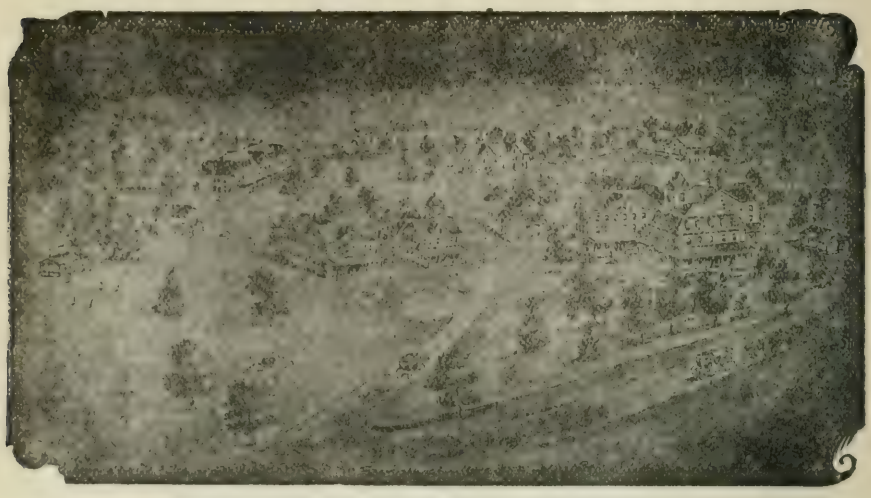

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# A CASE OF ACUTE SUPPURATIVE PERIHEPATITIS, OPERATION AND RECOVERY.*

By G. C. VanWart, M. D., (Univ. Penn.) Fredericton, N. B.

M. R., male, unmarried, age 21, address Fredericton, N. B., occupation, laborer in a saw mill; was admitted to the wards of Victoria Public hospital on December 26th, 1902.

Previous history: Born in England; came to New Brunswick as an emigrant about ten years ago. Previous health good, without any serious illness. Family history: Negative. Present sickness began December 20th, 1902.

Present state: He has slight aphasia; temperature, 101.4° Fah.; pulse, 80; respiration, 20; skin, dry; tongue, very much coated; breath, offensive; no sweating chills or jaundice; bowels, loose; digestion good; no nervous symptoms other than aphasia; heart and lungs, normal; urine, high colored (febrile appearance) sp. gr. 1024; sugar, albumen and bile, nil; no tube casts or sediment; abdominal symptoms, slightly tympanitic; no eruption. The lower border of the liver extends anteriorly one inch below the costal margin of the ribs and is very tender on pressure. Unilateral muscular rigidity over the right hypochondriac region.

History of illness: On December 19th, while handling lumber and reaching above his head, patient felt a pain in his right side. The following night the pain became more severe with cramps. He called in physician, who treated him for the abdominal pain and ordered the side, i. e., the part below the ribs, painted with iodine. During the next day the cramps subsided but the pain in the side continued. He had nausea, vomiting and looseness of the bowels. The temperature kept rising. He had been ill a week. A provisional diagnosis of enteric fever was made. His attending physician advised him to go to the hospital. On admission he came under my service. After a careful examination I concluded there was pus in or about the liver. The cause and exact location were the interesting points. I decided that an exploratory incision was the only rational remedy. The result—an uninterrupted recovery—proved it.

The conditions to be thought of in the diagnosis were:

*a.* Enteric fever with rapid onset.
*b.* Abscess of liver itself.
*c.* Abscess between liver and thoracic wall.
*d.* Abscess of abdominal wall.
*e.* Perihepatitis fibrinous or suppurative.
*f.* Right sided pleurisy with effusion.
*g.* Right sided empyema.

*Read before Meeting of Maritime Medical Association, Halifax, July 6th, 1904.

*h.* Subphrenic abscess.
*i.* Appendicitis with appendix pointing to the liver.
*j.* Cholicystitis and cholangitis.
*k.* Abscess about the right kidney.

In making a differential diagnosis the physical signs were abdominal, not thoracic. Previous good health, sudden onset, localized pain and tenderness on pressure, a history of traumatic irritation and muscular rigidity pointed to pus about the liver. The absence of chills and sweating excluded pus in liver proper.

Operation December 28th, 10 a. m. An incision was made beginning two inches below the costal margin of the ribs in line with the tenth, downward and outward for three inches. On examining the middle of the right lobe of the liver anterior and upper surfaces I could detect fulness and fluctuation, also slight adhesion between the liver and thoracic wall, The appendix vermiformis was located. It was normal, lying upward and to the right, outside of caecum and colon.

I opened the swelling with my finger, having previously walled off the adjacent parts with sterile gauze. A free escape of odorless pus followed. With my finger I could feel the capsule of the liver intact. The cavity was well wiped out with sterile gauze pads. A piece of gauze drainage was inserted to the bottom of the cavity and extended to the outside of the abdominal incision, a copious sterile dressing applied, and over all an abdominal bandage.

December 29th—Outside dressing removed. Free escape of odorless pus. Patient comfortable.

December 30th—a. m. temperature, normal; pulse, 80; p. m., temperature, 100 Fah.; pulse 86.

December 31st—Gauze drain removed and cavity irrigated with normal saline solution. A piece of rubber drainage tube was introduced.

The wound was irrigated and dressed daily until pus ceased to come away. It was allowed to heal by granulation.

January 2nd, 1903—Pulse and temperature normal and continued so until discharged from the hospital on February 14th, cured.

July 1903—Patient reports he is in good health. Has taken on flesh. Incision sound.

October, 1903—Patient left Fredericton and in April, 1904, I could not locate him.

This is a case of acute suppurative perihepatitis due to traumatism. The rarity and points in diagnosis led me to report the case. All lesions simulating pus in or about the liver demand exploration. Every effort should be made to establish a diagnosis before operation; yet, an exploration must eventually be depended on. In this, as in almost all acute abdominal lesions an adverse opinion cannot be sufficiently well grounded to justify the abandonment of surgical treatment. An autopsy has often shown a lesion that surgery with safety might have remedied.

## Case Reports.

### A CASE OF ECLAMPSIA.

By C. P. Bissett, M. D., St. Peter's, C. B.

On May 12th at 3 p. m., I saw L. C., aged 39 years, primipara, then 6½ months pregnant. This woman had noticed slight swelling of the face and hands, when suddenly she was seized with a violent convulsion in the course of which she suffered a laceration of the tongue. Three convulsions followed shortly after the first.

Dr. Fixott had charge of the case, and on examination of the urine made the startling discovery that by treatment with acid and boiling it became absolutely solid. Mental torpor became marked, and the mouth very offensive, with a constant oozing of blood from the gums.

Auscultation failed to discover the fœtal heart sounds, neither could any movement be excited by manipulation. It was therefore decided to at once empty the uterus. With rigid antiseptic precautions at every stage, the following proceedings were employed. A gum elastic catheter was passed between the uterine wall and membranes. In eight hours the os began to dilate. Barnes' bag was then introduced, and greatly distended. Pains became somewhat active in a few hours when the waters were broken and the dilatation completed with a Champitier de Rives hydrostatic dilator. Twenty-four hours from the beginning the woman was safely delivered. The temperature did no go beyond 99°F. Within fourteen days the albumen had almost completely gone from the urine, the woman making a good recovery.

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### SEVERE KNEE-JOINT WOUND.

By R. L. Murray, M. D., Springhill, N. S.

On November 5, 1903, William Henderson went to shoot partridges. But there were no partridges shot by William that day. He found game scarce and stretched himself on a mossy knoll for a rest, with his gun by his side. In getting up he reached for his weapon, took it by the muzzle and pulled it towards him. It was a careless manner in which to pick up a loaded gun, and a twig caught the trigger, and

it went off a few inches from him, and the entire load of shot struck him just below the patella. William's companion went to a near-by farmer's house, got a horse and waggon, and brought his wounded friend home.

On being callled to see him, I found the shot had entered just below the knee cap, severing completely the ligamentum patellae and shattering in innumerable fragments the patella. The pieces of bone, together with the shot and wadding, were mostly driven up a few inches above the knee into the quadriceps muscle. It was a nasty looking wound, the whole joint being exposed, but there was not much shock or loss of blood. Under chloroform the wound was further opened up the leg, all the patella taken out, with the shot and other foreign material. There was a split in the head of the femur running up about two or three inches. I made two extra openings on each side of the knee to provide for drainage. I left the whole thing open and bound up as cleanly as possible. I then irrigated the wound every day and it gradually commenced to granulate and fill up. The patient suffered at times from severe pain in the knee joint on the least moving or jarring of leg, and morphine had frequently to be given to quell the pain. With the exception of an abscess focus on the anterior part of the leg, about two weeks after the injury, the wound slowly healed. There was not much fever at any time. After three months he was able to go about on crutches, his leg being perfectly stiff, but the wound all closed up. He wore nothing around his leg but ordinary bandage. A month ago I was suddenly called to the house with the news that "Willie had broken his leg." It appears that he inadvertently backed off the sidewalk and the union between the femur and tibia was loosened and he had some motion at the former joint. I again made the joint immovable by plaster of Paris, and he is again going around with leg stiff with the immovable bandage on. I guess I will let him wear the bandage for some months to come.

THE

# MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XVI. HALIFAX, N. S., AUGUST 1904. No. 8

## Editorial.

### THE PROVINCIAL SANITARIUM.

The completion and occupation of a sanitarium for tuberculous patients at Kentville, which we announced in our last issue, is a matter upon which both the Government of Nova Scotia and the medical profession of our province are to be congratulated. For some years we urged action in this matter upon the Government, and it was in consequence of representations made by a deputation of physicians that the Government decided upon the erection of the building which has so recently been opened for the reception of patients. The credit for the conception and the advocacy of this institution therefore belongs, where it certainly should belong, to the medical profession, although it must not be forgotten that valiant support was given by the writings and the personal effort of the Rev. James Carruthers, lately of New Glasgow. And by the establishment and equipment of the model sanitarium at Kentville, the Government of the province has furnished another indication of its willingness to give countenance and furtherance to all such matters as appeal to the humanitarian instinct. From all we have learned about the sanitarium it is an exceedingly well planned, well constructed and well furnished institution, and one which redounds to the credit of Government and province.

While it is a great pleasure to speak in these commendatory terms of the building, it is unfortunately necessary to refer to some matters concerning the plan of administration which are not regarded with satisfaction by many members of the profession. One of these is the high charge which is made for the privilege of treatment there. It was the hope and expectation of the early advocates of a sanitarium that it would be free to those of limited means. It was, in fact, supposed that it was intended for those who could not afford to "take the cure" at their own homes. But a charge of $8.00 a week absolutely rules out all of limited means, and even restricts the length of sanitarium treatment of many whose income in health is only

sufficient to make them moderately "comfortable." We are informed that the charge at Saranac is only $5.00 a week, so that a patient deciding upon a three months' course could receive the treatment at Saranac, paying railway fares, etc., as cheaply as he could stay for a similar period at Kentville. Moreover, he would have the advantage of being under constant and skilled medical supervision, which is not the case at Kentville.

This leads to the second fault to be found with the administration of the Kentville sanitarium. There is no resident medical officer. The charge of the institution has been given to a very capable lady who has had much experience in nursing and in hospital administration. When she deems it necessary, she may call in a physician of Kentville to give medical aid. This cannot be regarded as a satisfactory arrangement, and we have learned that already an emergency demanding medical assistance has arisen which necessitated the despatch of a nurse in the night to search for the doctor, and a loss of time which might have proved very serious. There should certainly be a medical man in residence, who should have special skill in the treatment of tuberculosis.

Another ground of complaint is the plan adopted for the admission of patients. No patient may be admitted except upon the certificate of one or other of two physicians, and both of these reside in the city of Halifax. It certainly seems a hardship that a patient must needs travel say from Yarmouth to Halifax for certification, perhaps only to be found to be unsuited for treatment and so compelled to return home, sadder and wiser and also poorer.

The fact that the sanitarium has now been open for several weeks and that but very few beds have yet been occupied is a pretty certain indication that the want which the profession recognizes is not being filled by the present regulations. We feel quite sure that the government is anxious to make the institution all that it might be. Doubtless the present conditions are to be regarded as but experimental, and are to be attributed to lack of information. As time passes and the unsuitableness of the regulations now in force become evident to the government, proper amendment will surely be made. Meantime, however, much might be accomplished by members of the profession making such representations to members of the government as would assist them in determining upon a satisfactory modification of the present arrangements.

## MEDICAL FEES.

The question of fees for examination in life insurance occupied the attention of the Nova Scotia Medical Society at its last meeting. This question has frequently been raised by individual members of the profession and by county societies; and it is one which demands careful attention.

In our report of the business meeting of the Nova Scotia Medical Society, held on the 5th ult., it will be seen that the credit of bringing up the subject is due to the Lunenburg-Queen's Medical Society, which has decided to make this a five dollar fee. The reasons for taking this step, and the results up to this time, will be found in Dr. Burrell's remarks at the meeting referred to. It will also be seen from the reports in our present issue that the Maritime Medical Association has taken up the matter, and that it has also been favourably discussed at the meeting of the New Brunswick Medical Society.

We consider the action of the Lunenburg-Queen's Society to be well taken, and we trust the profession in these Provinces will be unanimous in adopting the five dollar fee.

As one result of the discussion to which we refer, the practitioners of Nova Scotia have now in their hands a circular drawn up by Dr. H. P. Clay in conference with Dr. W. H. Macdonald and Dr. March, (respectively Vice-President and President elect of the Nova Scotia Medical Society, and both members of the Lunenburg-Queen's Society). Accompanying this circular is a series of questions relating to the subject of fees in general, and especially to fees for life insurance examination, fees for government and corporation workers, and fees in courts-of-law; and to these questions an answer is desired from every member of the profession.

The question of fees or the valuation of medical services is not by any means a simple one, and perhaps it was never so keenly agitated or so prominent in medical societies as at this day.

There is one point quite certain and that is that medical fees are not to be arranged in the same way as the wages of tradesmen or the profits of shopkeepers. The health of the people is the chief asset of the nation, and notwithstanding the many stale jokes at our expense, we are the custodians of the public health.

In his daily rounds the practitioner may make visits which are not actually necessary, and the intrinsic value of much that he does may, in some cases, be slight, and yet the public sets a positive value on these visits, for the doctor is soon found fault with if he fails to call on the patient.

For a casual visit of perhaps five minutes in which nothing is really done by the doctor, save a cheering word to a convalescent, or a glance at a child's throat, a very small fee would be reasonable, in view of the value of time and the general financial condition of the community. But who is to estimate the value of the services rendered when the same doctor has battled successfully with a desperate case of placenta prævia, or, by prompt diagnosis and resolute treatment, and the possession of the necessary instruments and drugs, has saved the life of the child dying of diphtheria? Truly if our fees represented an average of the intrinsic value of our visits, *and were paid*, we should be "rich beyond the dreams of avarice."

The fact is that a medical scale of fees is an arbitrary arrangement determined in its general character by the paying power of the community, and not by any means an attempt to arrive at an average valuation of services rendered.

But in whatever way it is provided for, there is in every well regulated community a recognised scale of fees for medical services. The tariff must vary with circumstances. The fees in a backwoods settlement cannot be as high as in an old and prosperous farming country, nor is the practice in a small fishing village quite so great a financial prize as that in a fashionable residential quarter of a great city.

And it appears to us that as such conditions are readily acquiesced in, for the logic of facts is unanswerable, so also the logic of facts would indicate that in the great majority of general practices there must be variation in the fees charged to different individuals, in other words a sliding scale of fees.

This is a well recognized principle in Europe. We are all aware that in this very democratic country, whose ideas are so largely borrowed from the great Democracy beside us, all men are supposed to be born free and equal, this equality, so far as tariff of medical fees go, extending to wealth as well as position. We have even been told that it is a somewhat invidious if not insulting distinction to render Mr. A. a smaller account than Mr. B., for the same services, implying, we suppose, that he is not so good (that is so rich) a man. But, personally, we find that the distinction of a reduced fee is an insult very cheerfully condoned. But does not this system of a uniform fee seem very absurd? To have the same fee for the navvy as for the railway contractor, for the teamster as for the wholesale merchant, for the waiter as for the hotel proprietor, for the washer-woman as for Lady Blank, is it not ridiculous?

In England the inevitable stratifications of society are recognised in the tariff, which rises from the day labourer through the tradesman or shopkeeper, the farmer or professional man, to the Squire or landed proprietor. Would it not be possible in this country to have a tariff arranged on some reasonable differential, as for instance the assessment roll?

But, to return to the subjects of enquiry in Dr. Clay's circular. And first to a consideration of the fees paid in courts of law. The evidence given by a doctor is either ordinary or it is expert evidence. If expert, he should be paid as an expert. And if, in the nature of the case, he is not qualified to give expert evidence, it would be far better he should not be called at all. There are special points, as in cases of mental disease or other pathological conditions, in which it is impossible that a general practitioner can give expert evidence, any more than he can be a specialist in diseases of the eye or nervous system.

In cases where the evidence of a doctor does not involve profes-

sional opinion, he should be exempted from attendance as a witness. He is not exactly in the position of his fellow citizen, who may have to close his shop, or lose a day's work to serve on a jury or give evidence. Very often he can only leave his daily rounds at the peril of his patient.

As regards the fees paid by corporations and by the government, we can have only one opinion, namely, that no scale of fees can be satisfactory which has been arranged without conference with the profession, and that our self respect forbids that our fees should be dictated to us by any official.

Lastly, in considering the question of life insurance examination, which has been the immediate cause of this action on the part of the Nova Scotia Medical Society, we have to remember that the work of the medical man in this field is of a very important character, not only in the interest of the insurance companies themselves, but from a general socio-economic standpoint. We are all agreed as to the great value of life insurance. We know that the whole basis of a sound life insurance business is an intelligent appreciation of the expectation of life in the insured. Hence the requirement of a medical examination. It is evident that if this is carelessly done a grave risk is introduced into the prospects of the insurance company, and that means of course, the prospects of those who insure in it.

Our own view is that this should be a special department of medical work, and that it would pay the various companies to combine and employ an expert. This should be possible in large centres, but at present it is not likely to be adopted throughout this country. Now, having regard to the usual rate of remuneration for medical services in this country, we are of the opinion that the careful examination of a candidate for life insurance is certainly worth the fee of five dollars.

Cases vary : in some more than one examination may be necessary. The responsibility involved is grave. It would be a serious matter to pass an unsatisfactory applicant, serious for the company and serious for the examiner, if the early demise of the assured, and a possible *post mortem* should prove that his constitution was unsound. It is sometimes a serious matter also for the examiner when he refuses to pass an applicant, who unreasonably looks henceforth on the doctor as a personal enemy.

At a meeting of the Life Insurance Officers, Association, of Canada, held in 1902, a scale of fees was adopted and the examining officers were asked if they would agree to these fees. At the same time they were informed that the scale would come into operation on August 1st. So that there was no option. If a man would not agree to these fees, he could resign.

The fees adopted were as follows :

For assurance of $2000 and under.....$3.00

Over $2000 and under $5000.....$4.00
$5000 and upwards..... 5.00

"These fees to include a medical urinalysis in each case."

The rising scale from three dollars to five dollars, implies that the work is not necessarily as important in the event of a small insurance as a large one. This, we think, is a very serious mistake. It may be more important for the company when a man insures for a high rate but the work done by the doctor is precisely the same in an insurance for $1000 as for one of $100.000. And the lower fee certainly implies that such careful work is not expected.

And why, if this scale is adopted, does the fee stop at $5.00? If $4.00 for $4000 of insurance, and $5.00 for $5000, how much for $50,000?

At the same meeting of the Life Insurance Officer's Association the principle was adopted of a reduction in the fee when two or three joint lives are insured. "In the case of three joint lives, twice the ordinary fee will be paid for the three examinations." That is two days pay for three days work! Is there any parellel to this in any tariff of wages or of fees?

It is time for medical men to point out that they demand a share in the arrangement of their own fees. And if the members of the profession throughout Nova Scotia or the Maritime Provinces will follow the lead of the Lunenburg-Queen's Society, and stand by each other as they have done, they must secure the by no means exorbitant fee of five dollars for such delicate and important services as the examination and determination of candidates for life insurance.

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## THE NEW SUPERINTENDENT OF THE NEW BRUNSWICK PROVINCIAL HOSPITAL

James Vickers Anglin, the newly appointed Superintendent of the Provincial Hospital for the treatment of mental diseases at St. John, N. B., was born at Kingston, Ontario, in April, 1860.

He was educated at Kingston Collegiate Institute, also at Queens University, where he took his B. A. degree in 1883, and his M. D., C. M., in 1886, after which he took post graduate courses in Edinburgh and London. During his medical course he was clinical assistant at Rockwood Hospital for Insane, Kingston. He was, for a short time, in general practice at Coaticoke, Quebec, but he relinquished it to become Assistant Superintendent at Allegheny County Hospital for the Insane at Pittsburgh, Pa., where he remained three years, going thence to Verdun Protestant Hospital for Insane at Montreal as first assistant.

He has been lecturer on mental diseases at Bishop's College for several years and gave expert evidence in the Shortis case.

# Society Meetings.

## NEW BRUNSWICK MEDICAL SOCIETY.

The New Brunswick Medical Society held its twenty-fourth annual meeting in the Council Chambers, St. John, on the 19th and 20th July.

The President, Dr. J. Douglas Lawson, delivered an Address, the subject being "Medical Societies, their Beginning and Development."

The President received a vote of thanks and the address was handed to a committee for consideration and report.

On motion, the Medical Council was requested to hold its meetings at hours when the Society was not in session that the Society might have the advantage of the presence of the members of the Council and might also receive its report at the usual time.

Dr. G. A. Melvin, the treasurer, then gave his report, which was received, and Drs. W. L. Ellis and R. G. Day were appointed an audit committee. The meeting then adjourned.

### AFTERNOON SESSION.

The society resumed its session at three o'clock in the afternoon. The report of Dr. Skinner, registrar of the Council of Physicians and Surgeons, was then read as follows:

*Mr. President and Members of the New Brunswick Medical Society:*

The report which I have this year to make on behalf of the Medical Council contains matters of interest.

In my report of last year mention was made that steps had been abandoned to present to the Legislature a bill to bring the "Canada Medical Act" into effect in as far as this Province was concerned. This was decided upon with the knowledge that the Province of Quebec had declared against the bill. The New Brunswick Medical Council has always been in favor of the idea that a physician legally registered in one province should be able to practice his profession, if he so desired, in any of the Canadian provinces. It was a great disappointment to them, as it was to the majority of the medical men of the Dominion, that Dr. Rondick failed in his attempt to get legislation in the Canadian Parliament which would carry out this principle. However, the opposition in the Province of Quebec was sufficient to retard an advancement which we have strong hopes will come to pass within a few years.

Seeing that the "Canada Medical Act" was in abeyance, the Council, with the concurrence of the Nova Scotia Medical Board, proposed that a conference be held in Halifax during the meeting of the Maritime Medical Association.

Our Province differs from Nova Scotia in this respect: they have a teaching body and yearly graduate numbers of medical men, and so would naturally desire a wider field.. Quebec also stands in the same position. Last March a communication was received from the Secretary of the College of Physicians and Surgeons of Quebec asking: (1) On what conditions our Board would reciprocate with them in the granting of licenses. (2) What our Board thought of a general Interprovincial Reciprocity. The Council replied that we were strongly in favor of Interprovincial Reciprocity as outlined in Dr. Roddick's bill, and informed him of the proposal to hold a conference in Halifax suggesting that Quebec also should send delegates.

The conference was held in Halifax on July 6th. Representatives were present from Prince Edward Island, Nova Scotia and New Brunswick. It is pleasing to be able to state that the conference was in every way a success, and at the next meeting of this association it is expected that we will be able to report that Interprovincial Reciprocity has been consummated in as far as the Maritime Provinces are concerned. It is hoped that before long that not only will reciprocal registration be established throughout the Dominion of Canada, but that it will apply to the whole British Empire. It is of interest to note that at a recent meeting of the Ontario Medical Association a letter was received from the Colonial Secretary stating that a bill had been introduced into the British Parliament providing that for the purposes of the British Medical Act the King may declare any portion of the British possessions which is under both a federal and local legislature to be a separate British possession. When this bill becomes law the British Medical Council will have power to enter upon negotiations with any of the Canadian provinces to arrange for reciprocal registration without waiting for a Dominion registration. As matters exist at present in New Brunswick, a registered medical practitioner of Great Britain cannot enter upon the practice of his profession until he has passed the examination prescribed by the Council.

The Council is doing all in its power to compel all illegal practitioners to either become registered or cease from practicing. Recently active steps have been taken successfully against an offender of the Medical Act.

The following have passed the professional examination during the past year:—Dr. Isabella Wood, St. John; Dr. George Massicotte, Van Buren, Maine; Dr. Arthur S. Murphy, St. Stephen; Dr. J. R.

Byers, Montreal; Dr. William Warwick; St. John; Dr. Vernon L. Miller, St. John; Dr. Arthur J. Losier, Tracadie; Dr. Clarence G. Folkins, Grand Manan; Dr George A. Wright, Sydney; Dr. N. P. Grant, Woodstock; Dr. Joseph Price, Campbellton; Dr. D. R. Arnold, St John.

The following have passed the primary examination :—C. Patrick Holden, St. John; Napoleon Michaud, Campbellton; H. C. B. Allen, Cape Tormentine.

On motion, the report was adopted.

The Audit Committee reported that the treasurer's accounts were correct, and that there was a balance to the credit of the Society of $243.73.

The reading and discussion of papers was then proceeded with.

Dr. F. B. Harrington, of Boston, exhibited an instrument, termed a ring, introduced by himself, for use in procuring intestinal anastomosis, in a somewhat similar manner to that of the Murphy button. The ring is made of aluminum, in segments, so that on the giving way of the catgut which holds for some days, the ring falls into several segments. Dr. Harrington gave an interesting artificial demonstration of the use of this ingenious instrument.

Dr. Atherton reported a case of removal of a very large ovarian tumor with a fibroid uterus.

Drs. Harrington and Murray MacLaren discussed the paper.

Dr. W. H. Irvine read a paper, entitled "Reflex Nervous Manifestations of Uterine Origin, simulating Disease of Remote Organs, Recovery following Operative Correction of Uterine Lesions.' Reports of such cases from practice. Discussion of this paper followed.

Dr. G. G. Melvin exhibited a case of "Dermatitis Papillaris Capillitii," a very rare disease, and then read a paper on 'Syphilis," which was discussed by Drs. Jas. Christie, Crawford and others.

Dr. G. A. B. Addy reported a case of "Chyluria."

## Evening Session.

The election of officers resulted in the following officials being chosen for the ensuing year :—President, A. R. Myers, Moncton; 1st Vice-President, E. T. Gaudet, St. Joseph's; 2nd Vice-President, Geo. N. Pearson, Sussex; Treasurer, G. G. Melvin; Corresponding Secretary, W. H. Irvine, Fredericton; Secretary, L. R. Murray, Sussex; Trustees, G. M. Deacon, Milltown; J. McNichol, Bathurst; J. C. Mott, St. John.

After considerable balloting it was decided to hold the next meeting of the Society in St. John.

The committee on the President's address, composed of Drs.

McCully and MacLaren, reported, recommending that the Medical Council be requested to have mailed each year. along with the Society's programme, to all registered practitioners of the province, a printed copy of the Council's report, with a statement of the receipts and expenditures. After considerable discussion it was agreed that this printed copy be distributed to the members on the opening of the first session of the annual meetings.

Dr. T. Morris read a paper on "The Relationship existing between the Physician, Druggist and Patient."

This paper gave rise to much interest and discussion in which Drs. Deacon, G. A. B. Addy, Irvine, Pearson, T. D. Walker, Myers and others took part.

The speakers were unanimous in their view that druggists frequently overstep the limits of their legitimate work, and that an effort should be made to stop or lessen the evil.

The subject was handed to a committee composed of Drs. T. Morris, Pearson, T. D. Walker and Myers, to consider and report at the next annual meeting.

After the meeting the assembly adjourned to the Neptune Rowing Club rooms where the proceedings were of a somewhat lighter nature. Refreshments were served with a generous hand, and Morton L. Harrison's orchestra provided selections of music which added greatly to the general enjoyment of the evening. As vocalists Stephen C. Mathews and J. Hogan gave great satisfaction.

After supper and music had been disposed of speeches were the order of the evening. To the toast of the City of St. John, Recorder Skinner replied in an able speech, in which he welcomed the doctors to St. John, and spoke very highly of the medical profession.

Dr. Daniel, M. P., said that latterly his mind had been taken up principally with matters not connected with medical work. He felt more qualified to give his hearers pointers on the Dundonald incident or on what the G. T. P. would not do for the country.

The Medical Council was also toasted and ably replied to by different members p: esent. Festivities were co: tinued to an early hour in the morning under the chairmanship of Dr. MacLaren.

July 20th.—Dr. A. S. Thayer, senior member of the staff of the General Hospital, Portland, and a past president of Maine State Medical Association, was present as a delegate from the latter organization. He was introduced to the meeting by the President and invited to take a seat on the platform.

Dr. Thayer, in addressing the Society, stated that he brought with him the greetings of the Maine Association, and hoped that delegates from New Brunswick would be appointed to attend the next annual meeting of his medical society. He regretted that he had been unable to be present at the earlier sessions.

A telegram was received by the secretary from Dr. G. M. Woodcock of Bangor, Me., expressing his regret at being unable to attend the meetings of the Society.

A paper by Dr. Wetmore on "Immediate Trachelorrhaphy," and a case report, forwarded by Dr. Rankin, of Woodstock, on "Cerebral Tumor in a Child," were then, on motion, read by title.

A communication forwarded by Dr. Wetmore, of Hampton, as representative of the Maritime Medical Association, and referring to fees for life insurance was then read by the secretary. The communication in question commented on the attempt to obtain medical examination for a less fee than the recognized charge of $5.00, and advocated united action in the matter. It was endorsed by the Nova Scotia Medical Society and the Lunenburg-Queen's Medical Society. Dr. T. D. Walker stated more in detail the views of the Maritime Medical Association as put forward at their recent meeting at Halifax. The association, he said, felt strongly on the matter, but they considered more could be done by the local and provincial associations, and that by the medical fraternity taking a determined stand the practice of life insurance companies endeavoring to obtain medical examinations for a reduced fee might be abolished.

Dr. Deacon (Milltown) referred to the unnecessary reduction of fees, and urged the Society to a united effort to secure proper treatment for the profession. He moved a resolution that the N. B. Medical Society endorse the action of the Maritime Medical Association, and that a committee be appointed to acquire information on the subject, and communicate with individual members of the profession throughout the province and report at the next meeting.

Dr. Pearson (Sussex) said he considered fraternal societies should be included in the motion. Speaking for himself, the I. O. F. gave more trouble as regards medical examinations than any other company or society. An equivalent fee should be received from the society, as, having gone into the question, he did not see any advantage in the I. O. F. over straight life companies, and there was no reason why the latter should pay more.

Dr. Deacon stated that his motion was intended to cover this point, and he thought the committee should take up the matter in full. There were many sides to be considered by the medical examiner, and as an instance he took exception to the life insurance medical report, when given to an agent, being read by him, and his thus acquiring knowledge of the private life of individuals in his own district.

After further discussion, Dr. Deacon's motion was carried unanimously.

Dr. Hetherington moved that a copy of the resolution be sent to the societies interested, which was adopted.

The chairman then nominated Dr. Deacon, Dr. Pearson and Dr. MacLaren a committee under the terms of the resolution.

Dr. T. D. Walker moved that delegates be appointed to attend the annual meeting of the Maine Medical Association next year. Dr. J. Douglas Lawson, the retiring president, Dr. A. R. Myers, the incoming president, and Dr. W. L. Ellis were nominated to represent the Society on the occasion in question.

Dr. Murray MacLaren read a paper on "Operative Treatment of Bone and Joint Diseases." A discussion on the paper followed, in which Dr. J. W. Daniel and Dr. Walker took part.

Dr. Deacon proposed that a vote of thanks to the medical profession of St. John be placed on record for their hospitality during the annual meeting to visiting members; Dr. J. Douglas Lawson seconded the motion.

The secretary announced the names of the committee of arrangements appointed by Dr. Myers for next year as follows: Drs. A. Lewin, H. D. Fritz, J. R. McIntosh, T. Lunney, W. L. Ellis and W. A. Christie.

After the customary votes of thanks to the Mayor of the City of St. John for the use of the council chamber, the members of the Society subsequently proceeded to the Public Hospital upon the invitation of Mr. Hilyard, Hospital Commissioner. Here Dr. Stewart Skinner showed a series of five cases of spinal deformity and discussed their nature and appropriate treatment.

The members of the Society were conducted through the hospital by Mr. Hilyard, and were shown the new and handsome children's ward and the numerous improvements and additions which have been made to the hospital during its recent restoration. The freshly painted wards, new flooring, new plumbing and lavatories were much admired, as well as many other changes, such as the Nurses' Home,—which has now been doubled in capacity, the new quarters for the attendants, and the improved ventilation.

There was then an informal pleasant gathering, at which a vote of thanks was tendered Mr. Hilyard for his courtesy.

In replying, Mr. Hilyard stated that there was now accommodation for over 130 patients, and that it was the determination of the commissioners to have this hospital as well equipped as any similar hospital in Canada.

The annual proceedings then terminated.

## MEDICAL SOCIETY OF NOVA SCOTIA.

The annual meeting of the Medical Society of Nova Scotia was held at the Queen Hotel, Halifax, July 5th, at 8.30 p. m., the president, Dr. M. Chisholm in the chair. The secretary, Dr. W. Huntley Macdonald, read the minutes of last meeting, which were confirmed.

The nominating committee was appointed as follows:—

Drs. E. A. Kirkpatrick, H. P. Clay, W. H. Macdonald, J. C. Churchill and J. A. Sponagle.

The *Sanitation Committee* was then asked to report.

Dr. Cowie said that several meetings had been held, and the committee had been sub-divided into several committees.

*Charities Committee.*—Copies of report would be ready next day.

*Vital Statistics.*—Some members of the government were favorable, but, when action was to be taken, pleaded poverty and could not see their way to pass it. We should appeal direct to the members of the counties, and then the government would have to pass the Act.

Dr. L. M. Murray reported on the *Health Act.* The Provincial Health Board has been abolished and a Provincial Medical Officer has been appointed. Other changes were referred to.

A resolution from the Cumberland Medical Society, endorsing the changes in the Act was then read.

Dr. D. A. Campbell said that all the County Medical Societies must take hold of the matter and thus we can better influence the government.

The President referred to the great amount of work done by the Sanitation Committee.

Dr. Trenaman moved that the same committee be appointed to carry on the work.

Dr. Hattie seconded the motion.

Dr. Clay said that the representatives for Cumberland County had stood by them, and hoped that the members for other counties would be made do the same. Motion put and carried.

Dr. C. D. Murray moved that circular letters be written to the different County Societies to support the bill and changes made by the committee.

The Secretary said there would have to be some condensation and reference made to the paragraphs which were added or amended.

Dr. Cowie agreed with this suggestion. He believed New Brunswick would be in line with us in reference to Vital Statistics.

Dr. C. D. Murray said the trouble is that in St. John the duties had to be done without a fee. It was *ultra vires,* for the Provincial Government had not the power to deal with it.

Dr. Cowie stated that *statistics* is under the Dominion Government, but the Provincial Government can pass an Act on Vital Statistics.

Dr. March referred to a Bureau of Vital Statistics, which existed years ago, but fell through.

Dr. Trenaman thought that the points raised by Dr. Murray had better be referred to the committee.

Dr. L. M. Murray then read report of the Cogswell Library Committee.

Dr. Clay moved that the report be received and adopted, which was seconded and carried.

The Secretary read a resolution from the Colchester County Medical Society as follows:

*To the Nova Scotia Medical Society:*

The Colchester County Medical Society, having considered the matter of medical witness fees in this Province, desires herewith to call the attention of the N. S. Medical Society to the urgent necessity of securing remedial legislation. This Society requests the Provincial Society to take action in this direction at its annual meeting in July, 1904.

By order of the Colchester County Medical Society, Truro, N. S., June 22nd, 1904.

SMITH L WALKER.
W. R. DUNBAR.
H. V. KENT.
*Committee.*

This resolution is fully answered by report of the Legislation Committee already referred to.

A resolution from the Lunenburg-Queens Medical Society re Insurance Fees was also read:

At a meeting of the Queens-Lunenburg Medical Society held June 14, 1904, the mimimum fee for Life Insurance was placed at $5.

The Society received a cordial invitation from the Lunenburg–Queens Medical Society to meet next year at Lunenburg.

The President said he would like to hear from some gentlemen of Lunenburg or Queens.

Dr. Burrell said that the stand taken by their Society was on several grounds. In the first place, the advice given was looked upon in the nature of a consultation, and they asked to be properly paid for it. It was not because some companies already pay the five dollar fee that the resolution was passed by the Society. This also includes Fraternal Societies, on the ground that they canvass against old line companies. Some companies have paid the fee, and some under protest. At the Society's meeting at Bridgewater three representative Life Insurance men were present, to show the supposed folly of the medical men. A committee of five was appointed to confer with these men further. The contention was the companies could not stand it

as the competition was so keen. The plea of poverty he considered far fetched. The companies offered to pay mileage in addition to the fee of three dollars. We did not agree to that but stood by our colors. He hoped the question would be a provincial matter, and show the Insurance Companies that we mean business.

Dr. G. C. Jones said the Lunenburg-Queens Society ought to receive great credit for their stand. If the Society is small in numbers, it is strong in composition, and able to make the Insurance Companies "sit up". The Medical Society of Nova Scotia ought to take some action, and, if united, the result we can easily see. The only argument, from an insurance point of view, is poverty, but poverty from a medical point of view is stronger.

He moved a committee be appointed to think over this matter, and report next morning.

Dr. C. D. Murray agreed with Dr. Jones' resolution.

Dr. Trenaman said he would gladly see it brought about. But in Halifax where there were about 70 physicians, a large number were not members of this Society, and therefore the Society could not control them. The responsibility was as great for examining an applicant for $1000 as $10,000.

Dr. Jones did not agree with Dr. Trenaman, as only a few of the Halifax physicians did not attend the Society. Besides every physician of the province belongs to the society as a statutory right.

Dr. Cowie said the question was not a new one in Halifax. Years ago a similar resolution was carried out by the profession in this city, but younger men came in and took the lower fee.

Dr. Sponagle referred to a joint examination of man and wife. In one case he only got $4.50 instead of $6.00. The Lunenburg-Queens Society ought to be commended for their loyalty.

Dr. Clay said that insurance societies have dictated their fees instead of the profession doing so. The Cumberland Society passed a resolution for five dollars, but did not get all the members yet, so thought better to refer it to the provincial society. The County of Westmoreland was near Cumberland and examiners might come from there. The insurance companies have threatened to send an inspector instead of having different examiners. He would support a resolution and would urge the profession in the province to take a similar stand.

Dr. Cowie stated that members from Westmoreland County could not practise in Cumberland as it was against the Medical Act.

Dr. D. A. Campbell said we could accomplish something at least, and that was to heartily endorse the action of the Lunenburg-Queens Society.

Dr. March thought it would be well to memorialize the members of the profession in Nova Scotia. A circular could be sent asking each member if he favored it or not. This would be a step in advance.

The resolution of Dr. Jones was then carried.

Dr. D. Stewart asked that a member of the Lunenburg-Queen's Society be appointed on the committee, they being more conversant with the matter.

The President appointed the following as the committee : Dr C. D. Murray, Dr. D. A. Campbell, Dr. W. H. Macdonald, Dr. R. H. Burrell, and Dr. A. J. Cowie.

Dr. L. M. Murray referred to the great amount of work done by Dr. Clay on the Legislation Committee, also the expenses incurred, and loss of time. He moved that the sum of $10 be granted him.

Dr. Trenaman had much pleasure in seconding the motion.

Dr. Cowie said that the Government kindly sent their attorney to get up the Act and he had spent a great deal of time over it. He would like to know if insurance business had fallen off in Lunenburg County.

Dr. Burrell answered that the agents on several occasions had offered to pay the extra two dollars out of their own pockets, but the Society refused this as a matter of principle.

Dr. Murray's motion was then put and carried.

Dr. D. A. Campbell referred to the needed revision of the by-laws of the Society. It would make ample provision for discussion of practical questions. He moved a committee be appointed to revise the constitution and by-laws.

Dr. Clay seconded the motion which was carried.

The following committee was appointed :—

Drs. D. A. Campbell, (Convener), W. Huntley Macdonald, M. Chisholm, J. Ross and F. W. Goodwin.

The Secretary here referred to the gift offered by Dr. Marcy at the last meeting. He had talked over the matter with Dr. Stewart and thought it had better be left in abeyance. And also that Dr. Marcy's gift of $20 might be supplemented by something from the Society.

Dr. Ross said that Dr. Stewart had made the suggestion, that the gift be given for the best " History of the Profession in Cape Breton."

Dr. D. A. Campbell thought it would be best accomplished by getting a series of local histories and all material available be used. Very little had been done in gathering annals of the profession in Cape Breton. It would be a good idea to accept the suggestion of Dr. Stewart.

Dr. Cowie moved that $30 be added to Dr. Marcy's gift for the history of the pioneers of the profession in Nova Scotia. The money would be well spent.

Dr. Chisholm said that as gentlemen who have already written on the subject could not well procure the material for Cape Breton, a second prize might be given for the Cape Breton paper.

The Secretary seconded Dr. Cowie's motion.

Dr. Clay asked how the funds of the Society stood.

The Secretary replied that the funds do not warrant giving a series of prizes each year.

Dr. Cowie's motion was put and carried.

Dr. Clay moved a vote of thanks be extended to Mr. Fairbanks, for use of room in Queen Hotel. This was seconded and passed.

Meeting adjourned till following morning.

July 6th, 9 a. m.—Meeting held at St. Paul's Hall.

Dr. Jones moved that business transacted last night be considered legal.

Dr. C. D. Murray seconded the motion. Carried.

The Committee re Life Insurance fees met last evening after the close of the meeting of the Medical Society of Nova Scotia and drew up the following resolution which it recommended to the Society.

"That whereas the Lunenburg-Queens Medical Society has memorialized the Medical Society of Nova Scotia, stating its action in regard to fees for Life Insurance examinations:

Therefore resolved that the Medical Society of Nova Scotia hereby endorses the action of the Lunenburg-Queens Medical Society, and strongly recommends that the various other County Medical Societies of Nova Scotia be urged to take action along similar lines, and further resolved that the Medical Society of Nova Scotia issue a circular letter to the registered practitioners in Nova Scotia requesting from them an expression of opinion upon this matter."

DICKIE MURRAY *Convenor.*
W. H. MACDONALD,
D. A. CAMPBELL,
R. H. BURRELL,

Dr. March moved the reception and adoption of the Life Insurance Committee's report. Dr. Clay seconded it. Carried.

Dr. Kirkpatrick then gave the following report of nominating committee:

Mr. President and Gentlemen,—Your committee beg to report as follows:

For President, H. A March, M. D., Bridgewater; 1st Vice-Pres., J. W. McLean, M. D.; North Sydney; 2nd Vice-Pres., M. E. Armstrong, M. D.. Bridgetown; Sec.-Treas., W. Huntley Macdonald, M. D., Antigonish.

Committee on Surgery—John McKay, M. D., New Glasgow, (chairman); C. A. McQueen, M. D., Amherst; H. K. Macdonald, M. D., Lunenburg; John Stewart, M. D., Halifax; John Roy, M. D., Sydney.

Committee on Medicine—D. A. Campbell, M. D., (chairman), Halifax; H. H. McKay, M. D., New Glasgow; James Sutherland, M. D., Springhill; S. W. Williamson, M. D., Yarmouth; F. S. L. Ford, M. D., New Germany.

Committee on Obstetrics—C. P. Bissett, M. D., (chairman), St. Peters; Dugald Stewart, M. D., Bridgewater; M. A. Curry, M. D.,

Halifax; H. V. Kent, M. D., Truro; N. F. Cunningham, M. D., Dartmouth.

Committee on Therapeutics—Arthur Birt, M. D., (chairman), Berwick; F. W. Goodwin, M. D., Halifax; John Churchill, M. D., Isaacs Harbor; J. G. Macdougall, M. D., Amherst; A. M. Hebb, M. D., Chester.

Sanitation Committee—H. P. Clay, M. D., (chairman) Pugwash; L. M. Murray, M. D., Halifax; A. P. Reid, M. D., Middleton; W. B. Moore, M. D., Kentville; W. Reginald Morse, M. D., Ohio.

The place of next annual meeting, Lunenburg.

Local Committee of arrangement to be named by the Lunenburg-Queens Medical Society.

Signed—H. P. Clay, W. H. Macdonald, J. A. Sponagle, John Churchill, E. A. Kirkpatrick, Nominating Committee.

Dr. Kirkpatrick moved that $25 be set aside to recompense any one who would attend to the suggestions of the Committee on Life Insurance. Dr. March seconded it. Carried.

Dr. W. H. Macdonald (Rose Bay) wished a minute added, that the society's thanks were due Drs. Sponagle and Miller.

Dr. Jones moved that the members of the Medical Society be asked to contribute $1 each to the campaign funds. Dr. Clay seconded it. Carried.

The President appointed Dr. Clay a committee of one to attend to the circular letter about to be issued to the medical profession.

The meeting then adjourned.

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## THE CANADIAN MEDICAL ASSOCIATION MEETING.

The meeting which takes place at Vancouver this month from the 23rd to the 26th, promises to be a great success. The party from the Maritime Provinces, on the special car from St. John, numbers sixteen in all as follows:

Prince Edward Island.—Dr. S. R. Jenkins, Charlottetown; Dr. P. MacLaren, Montague Bridge; Dr. J. C. Housten. Mrs. Housten, and Miss Sterns, Souris.

New Brunswick.—Dr. O. E. Morehouse and Mrs. Morehouse, Keswick.

Nova Scotia.—Dr. J. B. Black, Windsor: Dr. C. I. Margeson, Hantsport: Dr. F. S. Yorston and Mrs. Yorston, Truro; Dr. J G. Campbell, Springhill; Dr. G. M. Campbell and Mrs. Campbell, Halifax; Dr. J. Ross, Halifax.

## Obituary.

**Dr. J. H. McKay.**—The death of Dr. John H. McKay, of Truro which took place on the morning of the 3rd inst., has removed another of the older practitioners of that town.

THE LATE DR. J. H. McKAY.

For the electro-cut and the following excellent account of the life of Dr. McKay, which we produce nearly in full, we are indebted to the *Truro Daily News*:

"Everywhere we hear sincere regrets of the loss that we have sustained in the lamentable death of Dr. John McKay. He was universally liked; and his proverbial kind and genial nature made him friends wherever he was known.

Dr. McKay has been one of our most prominent and respected citizens for the last 30 years.

He was born in Pictou County in 1847, and moved with his parents to Truro in his youth. His boyhood was spent in Truro, and he received his early education in the old model schools in this town, then under the efficient headmastership of that well know educationist, J. B. Calkin, M. A., who is still one of our active and progressive citizens.

Dr. McKay also attended special classes in the Provincial Normal School under the Principalship of the late Dr. Forrester, Superintendent of Education for Nova Scotia. His medical studies were commenced with the late Dr. Samuel Muir, whose efficient office for training in preliminary medical work had a reputation that was quite extensive at that time.

After this, a course was taken in the College of Physicians and Surgeons, New York; then, as now, one of the very best medical institutions in the United States, and with honors, our young citizen graduated in 1868.

The young graduate was ambitious in his profession; and a generons father offering him further assistance for the prosecution of his studies elsewhere, Dr. John went to Edinburgh, and in 1871, most creditably passed the stiff examinations and became a Licentiate, both as a Physician and a Surgeon, from the Royal Medical College in that city.

After graduation for some time he had full charge of an extensive practice of a well known physician and surgeon in England, and the young Doctor indeed well "won his spurs" by the energy and intelligence he threw into his work, and by the success that he achieved. He then visited in many hospitals in England and Scotland, and crossed to the continent for the same purpose—to perfect himself in his chosen profession—spending considerable time in Paris.

After this, Dr. McKay returned and settled in our town, where for 32 years he has with energy, faithfulness and good to all, followed the pursuit of his noble and humane profession.

In his profession he was kindness itself. He never refused a summons to the sick bed, no matter what the condition of wild stormy weather, distance, the state of the roads, nor the indigent circumstances of the applicant. He was the poor man's doctor and friend, if ever there was one in this world. No wonder he was popular with all classes all over the country.

In politics Dr. McKay was a pronounced Liberal Conservative, and was President of the Liberal Conservative Association of Colchester at the time of his death. His name was more than once mentioned as a candidate for political honors; any such nomination he refused, but invariably worked for the nominee of his party with all his characteristic energy.

He was fond of athletic sports, did much to encourage the same, and for some time was President of the Truro Amateur Athletic Club. He was a first rate cricketer, and one of the very best of our keen curlers. He was a lover of good horses, and his carriage equipages, and handsome horses that he looked after with tender care, were the admiration of our people.

Dr. McKay added much to the life and liveliness of Truro; and his ever ready assistance, when our interests and good name were at stake, will indeed be missed.

A worthy citizen in the prime of life has gone from our midst. We would liked to have had our friend here with us a little longer ; but no, it was not to be,—"man proposes, God disposes ; " and, at the early dawn of that lovely summer morning, with wife, son and other friends by his side, he drew his mantle gently around him and peacefully passed away into the great Unknown.

Farewell ! a word that must be, and hath been—
A sound which makes us linger ;—yet—farewell

One of the largest funeral corteges that for years has been seen in our town, "solemn and slow" wended its way to the Truro Cemetery yesterday afternoon (August 6th,) the last tribute of respect that could be paid to the memory of the late Dr. McKay.

The services at the house were conducted by Rev. R. G. Strathie, M. A., formerly of St. Andrew's Presbyterian church, assisted by the Archdeacon of Nova Scotia.

The funeral was under Masonic auspices, the pall bearers being: Dr. Patton, Dr. Dunbar, Donald A. Fraser, John P. McDonald, W. H. Rennie, H. W. Yuill.

At the grave after a short service by Mr. Strathie, Worshipful Master G. A. Hall read impressively the beautiful service prescribed by the ritual of the Masonic Order, assisted by Rev. J. W. Godfrey, curate of St. John's Anglican church, also a brother Mason. The scene at the grave was most impressive, and with the Masonic fraternity, the assembled public, as they saw the last that was mortal of Dr. McKay placed in the sacred keeping of mother earth, in their hearts said :

"We cherish his memory here ;
"We commend his spirit to God who gave it ; and
"We consign his body to the dust"

## Book Reviews.

**The Man who Pleases and the Woman who Charms.**—By John A. Cone. Third edition, revised. Cloth, 16 mo., price 75 cents, postpaid. Published by Hinds & Noble, 31-35 West 15th St., New York.

The author of this little book modestly disclaims effort at originalty, in his preface, and is content to call his work that of a "collector"—in the literary sense of that word. And it is quite true that the reading of the book reveals thoughts which have already come to one, either in the process of one's own reasoning or in intercourse with others. But as Mr. Cone has given them to us, they are clothed with the authority and dignity which publication in book form lends, spiced with apt illustrative quotations from great authors, and artistically wrought into a very interesting and readable monograph. "The points of conduct, the marks of breeding that spell success" are very well considered and very attractively presented. The great value of a pleasing address, tactful manners and cheery ways, in all the

affairs of life, are well known. Mr. Cone's book emphasizes these things and sets forth the ways by which anyone may acquire the accomplishments which mark the cultured man. Of course the book is intended for the general reader, but the physician can profit quite as much as anyone by its perusal, for to whom is the possession of the social graces of greater import than to the physician? The work has been very warmly praised by the press generally, and we have pleasure in adding our commendatory word.

**Manual of Materia Medica and Pharmacy** —Specially designed for the use of Practitioners and Medical, Pharmaceutical, Dental, and Veterinary Students. By E. Stanton Muir, Ph.G., V.M.D. Instructor in Comparative Materia Medica and Pharmacy in the University of Pennsylvania. Third edition, Revised and Enlarged. Crown Octavo, 192 pages, Interleaved throughout. Bound in Extra Cloth, $2.00 net. F. A. Davis Company, Publishers, 1814-16 Cherry Street, Philadelphia, Pa.

This is a work resembling somewhat Squire's Companion and is an admirable book of reference for those who use the U. S. P The first part gives some outlines of botany as a preliminary to description of medicinal plants.

The second part consists of Materia Medica proper, and the third is devoted to pharmacy.

The pharmacology and therapeutics of drugs are touched upon in the briefest way.

Dosage for domestic animals as well as man is given in the work, thus making it useful for veterinarian.

The book is especially suitable for druggists. For medical students and doctors, it is a handy book of reference.

For students of medicine however, we think it is best to combine with the dry details of materia medica and pharmacy, plentiful quantities of the more interesting discussions on the action and uses of medicines.

The latin accidence is dry work until it is illustrated in the work of translation.

Copious interleavings of blank pages furnish room for notes.

One could gather from other sources the most approved doctrines of pharmacology and therapeutiss and insert them in these blank spaces.

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## Therapeutic Notes.

Opium Neurosis.—I am very much pleased with Sanmetto. It is a very valuable preparation and should be in the hands of every specialist who treats the opium neurosis. In such conditions there is always considerable urethral inflammation besides other diseases of the genito urinary organs; but opium users are obliged to take twice the quantity of Sanmetto usually prescribed, to produce good results.

Germantown, Phila., Pa. P. H. Griffin, M. D.

Neurotic conditions in Women.—Prof. Charles S. Vaughan, Chair of Gynæcology, Atlanta College of Physicians and Surgeons, writes: "Neuralgia constitutes the great cause of danger from the employment of hypnotics and narcotics, which only afford relief by numbing, but effect no cure. On the other hand, the formation of a drug habit rather aggravates the condition

from which relief was originally sought. Neurasthenia, neuralgia and other manifestations, either of an active or passive character, are common and are always peculiarly rebellious to treatment. Cerebro nervous affections peculiar to women associated with pathological disturbances of the reproductive organs are legion, and most trying to physician and patient. I have found nothing so well suited to these cases as Antikamnia Tablets, administered in doses of from one to three tablets and repeated every one, two or three hours according to the attendant's judgment. These tablets afford complete relief without fostering a drug habit and their exhibition is attended with no unpleasant after effects. For the relief of painful menstruation there is no combination of remedies so generally successful as Antikamnia & Codeine Tablets. Their sedative, analgesic and anodyne properties especially commend them in the neuralgic and congestive forms of this distressing affection."

Hay Fever.—Any reliable remedial agent that is valuable in the treatment of this malady is welcomed both by the physician and his patients who may be hay fever suffers. The etiology, prophylaxis and treatment of this affection have often been the subject of study and experiment by physicians and also by intelligent laymen. The disease has been described as a catarrhal affection of the conjunctiva and the mucous membrane of the respiratory tract, characterized by an annual recurrence at about the same date in a given case. Another view is that the disease is a neurosis, and that the local symptoms (rhinorrhea, sensory disturbances, etc.) are due to vasomotor paralysis. The most conspicuous symptoms of hay fever are a burning and itching sensation in the nasal passages; profuse lacrimation: and then, febrile manifestations; frontal headache; and not in a few cases, asthma. The diagnosis having been established the subject of prevention and treatment is of the utmost importance. It would be utterly useless and wearisome to attempt to review the list of remedies and the methods of treatment that have been proposed for this disorder. The interests of physicians and patients will best be served by a brief recital of facts respecting the most successful mode of treatment known at this time. A glance at the list of symptoms and a brief consideration of the pathology of hay fever lead to the immediate conclusion that the chief indications are to check the discharge, allay the irritation that gives rise to the paroxysms of sneezing, reduce the turgescence of the nasal mucosa and relieve the stenosis. The only single remedy that meets these indications is *adrenalin*, as represented in Solution Adrenalin Chloride and Adrenalin Inhalant. By stimulating the vasomotor supply it contracts the arterioles, and thus promptly and efficiently relieves all the annoying symptoms referable to vasomotor paralysis. Moreover, by its powerful astringent action upon the mucous membrane, it blanches completely in a few minutes, and renders to the patient a positive degree of comfort. Indeed the results that have been accomplished with Adrenalin in this field alone are remarkable, and of the utmost importance. Messrs. Parke, Davis & Company, Manufacturing Pharmacists and Biologists, of Walkerville, who offer this valuable astringent agent, have also prepared a very complete treatise on hay fever, asthma, bronchitis and similar troubles, with full information relative to the treatment of these maladies with Adrenalin and other other agents. This booklet has already been forwarded

to a number of physicians who have applied for the same, and others interested in the subject can obtain a copy, post paid, by applying to this firm.

As an antiferment, to correct disorders of digestion, and to counteract the intestinal putrefactive processes in the summer diarrheas of children, LISTERINE possesses great advantage over other antiseptics in that it may be administrated freely, being non-toxic, non-irritant and non-escharotic: furthermore, its genial compatibility with syrups, elixirs and other standard remedies of the Materia Medica, renders it an acceptable and efficient agent in the treatment of diseases produced by the fermentation of food, the decomposition of organic matter, the endo-development of fetid gases, and the presence or attack of low forms of microzoic life.

An interesting pamphlet relating to the treatment of diseases of this character may be had upon application to the manufacturers of LISTERINE.

Bruises, sprains and abrasions consequent upon tennis, golf, mountain climbing and other out door sports are prevalent at this season. Infected wounds are frequent and disabling. Country life also brings the results of contact with poison-ivy, poison-oak and the various venomous insects with their characteristic weapons of offense. In all these cases the physician's first thought should be Antiphlogistine. It reduces inflammation of all sorts better and more quickly than any other application, while for poisoned wounds and dermatitis venenata it is almost a specific.

## THREATENED ABORTION

In these cases Hayden's Viburnum Compound exerts a sedative effect upon the nervous system, arrests uterine contraction and hemorrhage and prevents miscarriage. It has proven of special service in habitual abortion.

## THE RIGID OS

This condition, which prolongs labor and so rapidly exhausts the patient and endangers the life of the fetus is of common occurrence. H. V. C. acts most promptly and effectively and is not a narcotic. No less an authority than H. MARION SIMS, M. D., said:

"I have prescribed Hayden's Viburnum Compound in cases of labor with Rigid Os with good success."

A more convincing argument could not be presented.

# POSITIVE RESULTS IN OBSTETRICAL PRACTICE

WHEN YOU PRESCRIBE

# H. V. C.

(Hayden's) (Viburnum) (Compound)

## AFTER-PAINS

The value of H. V. C. after the third stage of labor cannot be overestimated Its antispasmodic and analgesic action modifies and releives the distressing afterpains and quiets the nervous condition of the patient. By promoting the tonicity of the pelvic arterial system it prevents flooding and thus eliminates the dangerous element in obstetrical practice.

## A WARNING

The enviable reputation of the Viburnum Compound of Dr. Hayden, H. V. C., in obstetrics and in the treatment of diseases of women, has encouraged unscrupulous manufacturers to imitate this time-tried remedy. If you desire results, you must use the genuine only—beware of substitution.

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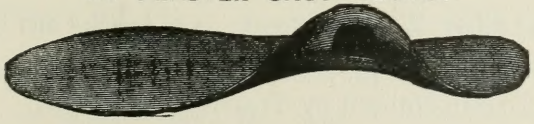

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The principal orthopedic surgeons and hospitals of England and the United States are using and endorsing these Supporters as superior to all others, owing to the vast improvement of this scientifically constructed appliance over the *heavy, rigid, metalic plates* formerly used.

These Supporters are highly recommended by physicians for children who often suffer from *Flat-foot*, and are treated for weak ankles when such is not the case, but in reality they are suffering from *Flat-foot.*

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**A Vitalizing Tonic to the Reproductive System.**

SPECIALLY VALUABLE IN
PROSTATIC TROUBLES OF OLD MEN—IRRITABLE BLADDER—
CYSTITIS—URETHRITIS—PRE-SENILITY.

DOSE:—One Teaspoonful Four Times a Day. **OD CHEM. CO., NEW YORK.**

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SOLUTION
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1:1000
A solution of the blood pressure raising principle of Suprarenal Gland
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Adrenalin chloride, - 1 part.
Normal sodium chloride solution (with 0.5% Chloretone), 1000 parts
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# HAY FEVER

## "THE MOST RATIONAL AGENT."

Prominent medical men say this of *SOLUTION ADRENALIN CHLORIDE* in the treatment of Hay Fever. Diluted with four or five times its volume of normal salt solution and sprayed into the nostrils, this marvelous astringent and vasomotor stimulant affords prompt relief. Two or three applications daily usually serve to keep the patient in a state of comparative comfort.

*Supplied in ounce glass-stoppered vials.*

NOTE.—We also supply ADRENALIN INHALANT, a neutral oil solution containing 1-1000 Adrenalin Chloride (in ounce vials), and ADRENALIN OINTMENT, 1000 parts of a neutral base and 1 part Adrenalin Chloride (in collapsible tubes), both admirable agents in Hay Fever.

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